PUBLIC HEALTH NURSING

FEBRUARY
1949

THE season of throat affections is here.

Thantis Lozenges have proved especially effective in soothing and relieving these conditions. The effectiveness of Thantis Lozenges is due to two active ingredients:

Merodicein* an antiseptic which prevents the development of bacteria even in great dilution

Saligenin† a mild local anesthetic which relieves the discomfort of throat infections.

Thantis Lozenges are antiseptic and anesthetic for the mucous membranes of the throat and mouth. Complete literature on request.

Supplied in vials of twelve lozenges each.

* Merodicein is the H. W. & D. trade name for monohydroxymercuridiiodoresorcinsulfonphthalein-sodium.
† Saligenin is orthohydroxybenzylalcohol, H. W. & D.

Thantis Lozenges

HYNSON, WESTCOTT & DUNNING, Inc.

Baltimore 1, Maryland

Press of Thomas J. Griffiths Sons, Inc., Utica, N. Y.

PUBLIC HEALTH NURSING

VOL. 41, NO. 2 FEBRUARY 1949

CONTENTS

PUBLIC HEALTH NURSING

Editor: MARY EDWARDS SHAW *Editorial Consultant*: HEDWIG COHEN, R.N.

 Published monthly. Entered as second class matter April 1, 1932 at the Post Office at Utica, New York, under the Act of March 3, 1879. Acceptance for mailing at special rate of postage as provided for in Section 1103, Act of October 3, 1917 authorized August 27, 1918.

Subscription rates of PUBLIC HEALTH NURSING for United States and possessions, the Americas and Mexico, are $4.00 per 1 year and $6.50 per 2 years (subscription rate to NOPHN members, 1 year $3.00). Foreign and Canadian add 50 cents per year. Single copies 45 cents. Rate in combination with *American Journal of Nursing*, $6.50 per 1 year. Rate in combination with *The Survey*, $7.75.

DEFINITELY USABLE BOOKS FOR THE PUBLIC HEALTH NURSE

Cromwell's Health of the School Child

The purpose of this book is to aid today's public health nurse in the effective performance of one of her prime functions in the community, namely, the preservation and conservation of the health of the school child. A detailed discussion is given on the findings of the School Medical Appraisal.

By GERTRUDE E. CROMWELL, R.N., M.S., Supervisor of Public School Nursing, Denver, Colorado. 256 pages, illustrated. $3.00.

Olson's Improvised Equipment

The public health nurse often meets situations undreamed of by nurses in other fields. Improvised equipment is her right hand and with it she is able to answer the needs of her patients. This handy little guide—with its step-by-step illustrations—will help her out no matter how unusual the situation.

By LYLA M. OLSON, R.N., Superintendent of Nurses, Kahler Hospital, Rochester, Minn. 265 pages, with 489 illustrations. $1.50. **Fourth Edition.**

W. B. Saunders COMPANY

West Washington Square Philadelphia 5

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

1790 Broadway, New York 19, N. Y.

ADVISORY COUNCIL

BOARD OF DIRECTORS

*Member of the Executive Committee.

MAGAZINE COMMITTEE

STAFF

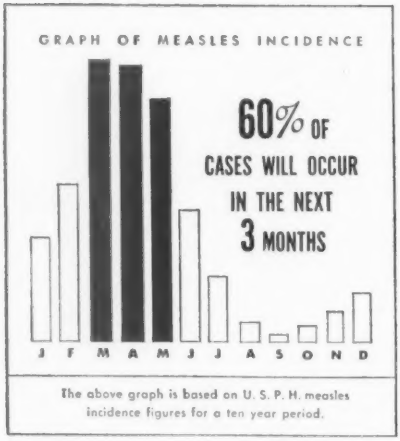
The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity. The acceptance of any of its recommendations is entirely voluntary.

Membership—Nurse, $5. General, $5. Sustaining, $10. Life, $100. Agency—Full dues 1% of annual expenditures for public health nursing service. Associate agency, $10.

6 OUT OF EVERY 10 CASES OF...

MEASLES WILL OCCUR IN THE NEXT 3 MONTHS



You can prevent or modify measles without fear of side reactions

There's one sure way of silencing crying youngsters and nervous mamas who complain about reactions – specify Cutter Immune Serum Globulin – Human. Successful results with this product are not happenstance. They come from:

1. The right raw material – fresh venous blood from normal donors.
2. The water-clarity of a hemolysis-free and non-pyrogenic product.
3. The concentration of 160 mgm. per cc. of gamma globulin – maintains consistent globulin potency yet permits low volume adjustable dosage:

For prevention –
0.1 cc. Immune Serum Globulin
For modification –
0.02 cc. Immune Serum Globulin
} ***intramuscularly, per pound body weight***

Prepare now for measles' peak season just ahead. Notify your pharmacist the amount of gamma globulin you expect to use – and specify Cutter.

CUTTER LABORATORIES • BERKELEY 10, CALIFORNIA

be prepared with –

IMMUNE SERUM GLOBULIN – CUTTER

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

PUBLIC HEALTH NURSING RESPONSIBILITIES

THE FIRST comprehensive statement of public health nursing objectives and functions was issued by the National Organization for Public Health Nursing in 1931. The original statement was prepared for the purpose of:

1. Guiding the individual staff nurse
2. Giving nursing organizations a yardstick for use in checking the extent to which the agency objectives had been reached
3. Furnishing health officers with information helpful in appraising their nursing services
4. Answering the layman's question "What does a public health nurse do?"
5. Guiding the student and the teacher in schools of public health nursing.

It is interesting to note that nowhere in the 1931 statement is the term "generalized public health nursing" used. The functions are enumerated under 12 separate and distinct headings. These headings include: maternity, infancy, preschool, school, and adult health service, morbidity, communicable disease, tuberculosis, syphilis and gonorrhea, orthopedic, industrial, and mental hygiene. A person unfamiliar with the philosophy of considering the family as a unit, would naturally conclude that each service was carried by a special nurse or a separate group of nurses.

The revised statements issued in 1936 and again in 1944 emphasized the generalized approach but again enumerated the functions under disease or age group categories. A few additional categories, such as sanitation, vital statistics, and nutrition were added in 1936.

In reviewing the previous statements, one is impressed with the number of functions which began with the words "assist" or "help." These verbs were used in describing more than 30 activities. Consequently some professional groups have wondered if public health nurses have a professional content of their own, or if they are employed to be "the handmaiden of the doctor" and are incapable of taking any independent action! In many of the activities mentioned, the nurse is of course a member of a team and her work is most effective when it becomes an integral part of the total health program.

The Subcommittee on Functions of the Committee on Nursing Administration appointed by the National Organization for Public Health Nursing to prepare the 1949 revision is made up of representative nurses of local and state health departments, voluntary nursing agencies, university public health nursing faculties, and federal agencies. The committee agreed that the statement should be directed primarily to health administrators and appropriating bodies, such as county com-

missioners, city councils, community chests, community health councils, and boards of voluntary nursing agencies. While such a statement may be useful to nursing school faculties and students, to inexperienced public health nurses, and to nursing supervisors, this statement may not meet the specific needs of those groups.

Instead of repeating considerable information regarding organization of public health nursing services and desirable qualifications for public health nurses, the new statement refers to earlier publications "Recommended Qualifications for Public Health Nursing Personnel" and "Desirable Organization of Public Health Nursing for Family Service." Since the broadest aspect of public health nursing is presented in this statement, it is titled "responsibilities" and no distinction is made between those responsibilities which are usually assumed by supervisors, staff public health nurses, or auxiliary nursing personnel, since the functions of each worker may depend, to a certain extent, upon the number and types of workers available in that area.

The committee would like to emphasize again that this statement is prepared particularly for health administrators, appropriating bodies, and boards of directors of voluntary agencies. In view of the pending federal legislation designed to expand greatly the development of local health units, this approach appeared logical. The statement is not a "job analysis" type of description of public health nursing functions. However, the committee believes that it emphasizes the vital part public health nursing plays in the total community health program and that it shows the nurse as a responsible coworker on the professional health team.

PEARL MCIVER, R.N.

COMMITTEE ON FUNCTIONS

PEARL MCIVER, R.N., *Chairman*
MARTHA D. ADAM, R.N.
MRS. EVELYN A. BALGINY, R.N.
ALICE F. BRACKETT, R.N.
IRENE CARN, R.N.
NAOMI DEUTSCH, R.N.
RUTH FREEMAN, R.N.
MILDRED C. LANT, R.N.
MARION I. MURPHY, R.N.
MARY E. PARKER, R.N.
RUTH E. TELINDE, R.N.
JEANETTE VROOM, R.N.
RUTH FISHER, R.N., *Secretary*

PUBLIC HEALTH NURSING RESPONSIBILITIES IN A COMMUNITY HEALTH PROGRAM

The Subcommittee on Functions of the NOPHN Committee on Nursing Administration prepared this statement for public health nursing administrators and others interested in public health nursing, and for employers of public health nurses, to guide them in determining which responsibilities in a health program public health nurses can best carry out by reason of their education and experience.

PUBLIC HEALTH has made rapid progress since 1900. During the early part of the century major emphasis was placed on environmental sanitation and the control of communicable diseases. For the most part control measures of health departments were restrictive rather than educational, and were directed towards groups rather than individuals. Later, as health programs broadened, attention focused on the education of individuals and families in the prevention of disease. Today the objective of a community health program is to bring to all the people the benefits of modern medical and related sciences, including (1) the care and rehabilitation of the sick and disabled (2) the promotion of healthful living and (3) the prevention and control of disease.

Public health nursing participation is required to put into action almost every phase of the health program. It was the unique contribution of public health nurses that they demonstrated the value of health teaching directed to the individual as well as to the group. Their work proved so beneficial that they are now by far the largest single group of professional workers in the public health field.

Although at first public health nurses were employed primarily for nursing care of the sick and for such specific programs as tuberculosis control and maternal and infant hygiene, controlled experiments prove that service is most effective when each nurse gives all of the necessary public health nursing care to the families she serves. In addition, as one of the community's professional health workers, she participates in all activities that affect the entire health program.

Social changes, scientific advances, and the demands of people better informed in matters relating to health—all are factors affecting the extension of public health nursing. This broadening scope requires personnel with a comprehensive educational background. In preparation for their career, public health

nurses now acquire a greater understanding of the social sciences and of human behavior, as a basic requirement for competence in the art and science of nursing, including health teaching.

While the scope of public health nursing is increasing, so are public health nursing responsibilities. These may be grouped under three classifications. All public health nurses whether they are administrators, supervisors, staff nurses, or whether they function in all three capacities, may be called upon to carry these out. The classifications of responsibilities are:

I. Nursing care and health guidance to individuals and families—at home, school, work, and at medical and health centers.

II. Collaboration with other professions and citizen groups in studying, planning, and putting into action the community health program.

III. Participation in educational programs for nurses, allied professional workers, and community groups.

I. *Nursing Care and Health Guidance to Individuals and Families —at Home, School, Work, and at Medical and Health Centers.*

The responsibility of public health nursing is to:

1. Provide on a part-time basis skilled nursing care under nursing direction and give treatment, under medical direction; demonstrate, teach, and supervise the nursing care that families, practical nurses, or other workers may assume safely in the absence of the public health nurse.

2. Guide families to recognize their medical, nursing, and health needs and give counsel appropriate to the situation and the families' recognition of their needs.

3. Interpret to individuals and families the implications of the medical diagnosis and guide them in carrying out the treatment and regimen recommended by the physician.

4. Guide individuals with social and emotional difficulties to appropriate community agencies when indicated.

5. Perform, under the direction of a physician, diagnostic tests and preventive immunizations, and interpret the findings of the tests to individuals and families.

6. Work with families to secure and maintain satisfactory environmental conditions that will prevent disease and accidents.

II. *Collaboration with Other Professions and Citizen Groups in Studying, Planning, and Putting into Action the Community Health Program.*

The responsibility of public health nursing is to:

1. Participate in finding new and early cases of illness by taking part in the planning and conduct of field investigations, epidemiological studies, and examinations of selected groups.

2. Share in the collection, analysis, and interpretation of records and statistics significant to the development of needed health services.

3. Formulate and evaluate an organization's nursing program and procedures to insure economical use of nursing personnel and sound correlation of work with that of other community health and social agencies.

4. Make periodic cost and time studies to determine if expenditures for nursing are

distributed wisely and adequately in relation to the total agency budget and community health needs.

5. Participate in community planning for immediate and long-term health needs, including the coordination of existing nursing services, and for eradication of social and economic conditions known to contribute to poor health.

6. Participate in community planning for correlating nursing care in hospitals, clinics, schools, industries, and homes.

7. Work with citizen groups to develop community participation in public health and public health nursing services.

8. Participate in programs of public information and public relations for public health nursing and community health.

III. *Participation in Educational Programs for Nurses, Allied Professional Workers, and Community Groups.*

The responsibility of public health nursing is to:

1. Plan, conduct, and evaluate in-service educational programs for public health nurses.

2. Take part in planning in-service educational programs for other health personnel and for related community agencies—school, hospital, and social welfare organizations.

3. Instruct community groups in home nursing procedures, maternity care, or other subjects related to family and community health.

4. Cooperate with schools of nursing and universities in providing and preparing qualified faculty; and in planning and carrying out a program that will promote an understanding of community health among the nursing students and nursing staff.

5. Participate in plans to provide field practice for students enrolled in university public health and public health nursing programs, and for selected students of schools of nursing.

6. Share with other personnel of health organizations in providing field observations for students in allied health professions, and provide opportunities for selected visitors to observe public health nursing activities.

7. Interpret public health nursing opportunities to high school and college counselors, to educational administrators, and to students.

For information on qualifications for public health nursing and desirable organization of services the committee recommends *Desirable Organization of Public Health Nursing for Family Service,* and *Recommended Qualifications for Public Health Nursing Personnel.* And for a popular explanation of public health nursing they recommend *Know Your Public Health Nurse.* These publications are available from the National Organization for Public Health Nursing, 1790 Broadway, New York 19, N. Y.

POSTURE INSURANCE FOR INFANTS AND CHILDREN

MABEL L. FITZHUGH

"ONLY a few children, less than five percent, develop good posture spontaneously," Dr. John G. Kuhns has said. This is a challenge to all who are concerned with the health of the next generation, especially when we agree with the anatomist, C. W. MacKenzie, "If generalizations were to be made concerning the causes of human disease, they would be along the line of failure of accommodation to the erect posture."

How can we care for a baby in the way which will develop the best possible posture and with it the highest potential resistance to disease?

Perhaps the time to begin is at the beginning, with proper diet and exercise during the pregnancy to enable the mother to endow her child with a good foundation on which to build his own bone and muscle growth.

This article, however, is concerned with certain technics of handling infants and young children which have been found useful in developing strong, straight bodies and in preventing common postural and structural defects such as round shoulders, hollow chests, pot bellies, bow legs, knock knees, pigeon toes, and pronated feet.

Mrs. Fitzhugh has guided the posture of babies and preschool children for 13 years in San Francisco and San Jose. California's "Straight from the Start" and Connecticut's "Let's Keep Them Straight" are based on her work. She is now posture director of the San Jose Well Baby Conferences.

SLEEPING BABIES

The young baby spends most of his time in sleep and very early may acquire sleeping habits which are difficult to change.

The prone sleeping position has been found to contribute to many postural difficulties. If a tiny baby is placed on his face he will almost invariably draw his knees up in the fetal position causing a continuous pressure on his head, knees and feet. If he turns his face always to the same side, there may be pressure on one eye, or side of the jaw, hindering normal development. One side of the face and one eye may be smaller than the other due to continuous pressure against the bed. The weight of the buttocks pressing on the feet may twist them in or out, depending on their tendency at birth. (Figure 1) Pronated feet, bunion joints and crooked, over-lapping toes may have had their beginnings as a result of this position. Casts have been necessary to correct inverted feet after several months sleeping thus. The knee-chest habit persists in certain cases even up to five years. Increased bowing of the legs sometimes accompanies the inverted foot position, while knock knees seem to follow the everted feet.

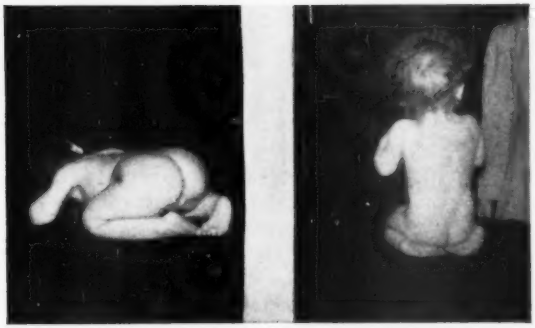


Figure 1. The results of a constant knee-chest sleeping position are unfortunate for the infant—often a one-sided development, pronated feet, and bowing of legs.

Continuous flexion of hip and knee joints leads to contractures of tissues which make full extension of these joints difficult when the child tries to stand and walk, thus contributing to lordosis in the lumbar region.

It is true that most babies seem to like the same prone position, get rid of gas and excess food easily, sleep quietly, and do not kick off the covers, but these reasons do not seem to compensate for possible danger since this habit may persist for years.

Back sleeping also has its difficulties. The back of the head may be flattened; or the baby may choke if he spits up in his sleep. His legs are spread wide by diapers and tightly tucked covers, preventing correct alignment. Many back sleepers resent being placed on their stomachs and cry, so their mothers let them stay on their backs, sleeping and waking. They may have been able to raise their heads easily when prone at birth, but find it difficult after two or three months. The extensors of neck and back seem to become weaker through lack of use. There are a few exceptions found in certain children who will arch their backs and turn over in spite of lying on them all the time. Many back-lying children never learn to creep and are thus deprived of the uniform muscular development resulting from this exercise. These children are usually fat, good-natured babies, slow to learn to sit, stand and walk.

Dr. Edward A. Strecker says: "In building a child's personality the opportunity for physical motion must be provided and the inborn desire to move must be encouraged. That is how a child learns. . . . You have probably heard a mother boast that her child is quiet and well-behaved. It is a stupid boast. Psychologically speaking a quiet child is not a normal child. A quiet child is being deprived of the opportunity of getting its first growth of mind. The sensations that flow into the personality of a child through the route of motion are as necessary to its mental growth as the milk which it receives from its mother is for its physical growth."

A four-sided program of lying positions each day has been found to give the best all-round development. Beginning at birth the baby should be placed on alternating sides for sleeping, and on stomach and back while awake. Thus the natural bowing of the legs is straightened while the bones are most flexible. The feet tend to take a neutral position. Any tendency to round shoulders is counteracted by spreading the baby's hands wide apart when he is lying on his face when awake.

The tiny infant enjoys the security of a blanket roll at his back only, leaving his head free. But a pad placed under his head keeps its weight off his shoulder. It should

be thick enough to keep his neck level with his spine. A small bath towel folded and slipped into a baby pillowcase makes a good pad but use no pillow when the baby is on back and stomach. The blanket roll needs to be tied firmly. After the baby has learned to turn over of his own accord these aids can be discarded as these children usually sleep in a great variety of positions, in itself good posture insurance.

BABIES AWAKE

Babies need to have all their joints carried to full extension at least once a day. They vary a great deal in their ability to do this unaided. The prenatal flexed position leaves its mark and the continuous wearing of diapers tends to keep hips and knees flexed. If the baby resists it must be done very slowly and gently, with a relaxed holding by the mother's hands.

The easiest and most enjoyable way to encourage full postural extension is to place the naked baby on his stomach on a firm table. Hold the thighs together well above the knees, touch his buttocks gently, then run the finger up the spine. Automatically the tense hips and knee flexors will relax as the extensors contract and the baby receives his first lessons in correct coordination of all his standing and walking muscles.

Sometimes a baby is seen with prenatal deviation of the feet which may need special correction. Gross conditions are cared for in the hospital, but the mother can be taught to correct a minor deviation before the child begins to stand.

If the feet are everted it is easy to stimulate inversion by turning the foot in and curling the toes over toward the sole. In a short time the baby will do this himself when the sole is touched, just back of the toes. This game may be taught every member of the family, for it needs a deal of doing if pronation is to be be prevented. Long continued standing with everted feet increases pronation, especially on the yielding surface of the bed, with legs spread wide by thick, tight diapers, arches sagging and knees pulled inward by gravity.

If the baby's feet are inverted at birth, the over-long peroneal muscles may be stimulated and trained by passing the finger gently up the outside of the ankle, thus causing the foot to turn out. This may be done ten times at each diaper change till the feet take the neutral position habitually. If the tendency persists up to ten weeks the doctor should be consulted.

Certain babies are born with the dorsum of the foot resting on the shin. If uncorrected early these children may be heel-walkers. This condition is also increased by standing in bed. The over-long calf muscles can be brought into balance by placing the hand against the soles of the baby's feet while doing the exercise for the extensor muscles described

Figure 2. Cradle the tiny baby, rather than hold him erect against the chest. At the right, a good way to bubble.

above. While the thighs are held together, the baby will push against the mother's other hand with the fore part of his feet, thus shortening the calf muscles.

The "good" baby who early learns to pull up to a sitting position and then *stays put* contentedly in bed, pen, carriage or chair is not having a fair chance to develop adequate muscle or correct alignment. In fact, he may lose the perfection with which he was born through the effects of gravity on his elastic tissues. Too much sitting in infancy may cause cervical lordosis, round shoulders, hollow chest, pot belly, and contracted hip flexors.

The urge to prop a tiny baby with pillows is very strong in the young mother, but measurements made at monthly intervals have shown that a perfect chest may begin to develop the groove and flare after only a month of this practice. The chest length may decrease and the abdominal length may increase.

The first time an infant is held in the perpendicular position all his organs may sag and his abdominal wall bulge, the beginning of ptosis en mass. X-ray studies of newborns show that the stomach is usually found close to the diaphragm in the recumbent position. "In the erect posture however, the greater curvature has been seen any place from the level of the first lumbar to the first sacral vertebra at various times in the same infant," states S. G. Henderson. Mothers need to be trained to carry their little babies cradled in their arms, with head and back supported, instead of in the erect position against their chests. (Figure 2)

This position also prevents damage to the neck vertebrae from the weight of the head, and possible curvature of the spine.

The baby may be bubbled with speed and safety by simply rolling him over so that his lower abdomen rests on the mother's thigh, his head and shoulders on her arm, a little higher than his buttocks. His back is gently rubbed, never patted. If there is gas in the lower bowel it escapes also. The mothers report less colic as a result of using this method. (Figure 2)

It is well also to train mothers in the need to be ambidextrous in handling their babies. If bottle fed, the mother should hold the baby on alternating arms.

The babies who are held, carried and laid in the horizontal position until, by their own unaided efforts out in the middle of the floor, they have learned to creep and then to push themselves up to a sitting position, build their own strong walls of trunk muscles. Lying on the floor seems to stimulate activity of all the trunk and limb muscles. It encourages squirming, rolling, kicking, stretching, arching the back, lunging, and in due time, uniform creeping with both hands and both knees. Certain active babies enjoy doing push-ups on hands and toes. The ability to sit erect with back perpendicular, head and chest held high and abdomen flat is honestly earned by this preliminary effort.

TOO MUCH SITTING

At one year of age there is marked contrast between these children and others who have been placed arbitrarily in the sitting position for much of their waking time. (Figures 3 and 4)

The habitual sitter is easily recognised by his short, sometimes tense neck muscles and contracted chest, flaring below into the typical potbelly. The girls are frequently overweight, especially between the waist and knees, a tendency which may persist. The pelvis may be deformed by the continuous pressure plus the inertia of the sixty muscles attached to it, which, during activity, tend to mold it by pulling in all directions. Normal development of the pelvic organs may be prevented.

Pens, canvas jumpers, walkers—all the devices used to keep a baby quiet and in one place only retard his development by preventing big muscle activity.

The go-cart should always have the footrest in place and never be used as a walker, since this may prevent a normal use of the walking muscles and may increase a tip-toe habit, or pronation and knock knees.

Many babies are seen on the street taking an afternoon nap, with head down on the tray of the go-cart, neck crooked and back round, chest cramped and organs pushed

Fig. 3. Early and long-continued sitting makes for a short neck and contracted chest, flaring into the typical potbelly.

down. It would be a good idea to instruct the police to arrest their mothers on a charge of cruelty to babies.

EXERCISING THE VERY YOUNG

Nature supplies an excellent exercise which young babies should be allowed to practice for short periods every day. Just watch a baby cry. He takes in large supplies of oxygen, so necessary to his health, especially his brain cells. His chest swells out with the increased use of his respiratory muscles, and his abdomen becomes as hard as an athlete's. He kicks and beats the air with his fists.

There is no other exercise which gives so much benefit in so short a time, even creeping. It is interesting to note the difference between the babies who have cried awhile every day in early infancy and those who were prevented from crying. The chests of the former are full and have parallel sides, the abdomens are flat and firm (if not spread by too much sitting); while the latter are apt to have short, narrow chests and doughy, prominent abdomens.

Climbing is one of the natural urges of little children. Babies who creep can often climb a little ladder before they can walk. The mother stays close by while the little one is learning to come down by himself, for each experience must be a complete experience. (Figure 5)

The fearful mother who prevents her child from exercising this instinctive urge when it first becomes active may be frustrating him in more ways than one. Depriving him of early opportunities to climb and surmount difficulties may hinder the development of a sense of competence and a satisfaction in achievement. It seems to give children valuable experience in self-control, coordination, and independence. It will do more to prevent posture defects and aid in correcting them than any other exercise.

If possible, the ladder should be perpendicular, securely fastened to the wall like the one leading up to the haymow in the old barn.

BAD HABITS MAY PERSIST

Many little children are required to occupy

themselves with coloring and cutting out pictures, stringing beads, many small toys and games,—anything that will keep them quiet and busy. They must begin to use the small muscles of their hands and eyes before these are matured in neuro-muscular coordination, perhaps leading to trouble later in life.

For many children the floor is the only place to do these things, so they squat, or sit on one foot with back crooked, or with both feet under the buttocks or out at right angles, and always leaning over. Or they may lie on their stomachs, propped on their elbows, with shoulders hunched and spine sagging into a swayback. (Figure 6)

A few minutes at a time in a bad position may do no harm if the child has plenty of activity otherwise, but several hours a day in a quiet child may leave tell-tale abnormalities in the structure of neck, chest, back, hips, knees and feet.

The growing child should be made comfortable in a correct position for eating and quiet play. He needs a table and chair that *fit* at all stages of growth, so his own furniture receives the same attention given his clothing and shoes. The chair seat should be an inch lower at the back than at the front, the right depth, and low enough for the child's feet to rest flat on the floor with no pressure under the knees. The back of the chair should support the middle third of his back, open at the hip level so there will be no pressure there to cause him to slide forward. Then he can sit comfortably with no strain or effort. The top of the table should be a little higher than the tip of his elbow when he is sitting straight. The cross piece under the top should not be wide enough to interfere with his knees. If the table is too high the child will hunch his shoulders when he puts his elbows on it; if too low, he will droop over it. Blocks can be put under the legs as the child grows.

If all small toys are systematically put on the table the child may become adjusted to playing there instead of on the floor, especially if the mother quietly takes them away for a few minutes, then puts them back on the table.

Children who must sit on adult chairs at mealtime are apt to become restless and lose their appetites due to discomfort, as well as the pressure on their stomach due to the

Figure 4. Plenty of sleeping in a variety of positions with little sitting helps to bring about the ability to sit and stand erect with back perpendicular, head and chest held high, and abdomen flat.

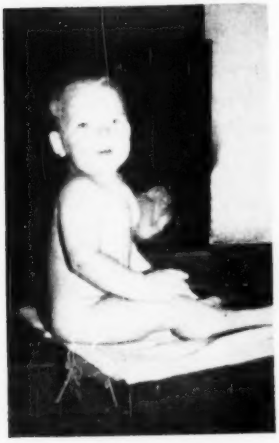


Figure 5. Going up and coming down. Climbing is a natural urge at an early age.

slumped position. It has been found that a footstool of the right height added to increased big muscle activity, especially climbing, helps many problem children to regain their appetites.

Swayback can be caused by the pull of tight hip flexors due to too much sitting in infancy. It is increased by sleeping on the stomach on a sagging bed, or with the head on a pillow, or by lying on the stomach to play or read, propped on the elbows.

Standing on the seat of the car with knees braced back against the back of the seat may increase swayback and is apt to cause a back knee deformity, especially in the loose-jointed child. The little child needs his own seat in the car.

There are many habits which may lead to a lateral curvature of the spine. Perhaps the most common is that of sitting on one foot, and always the same foot. This not only throws the spine out of line but may cause a crooked pelvis with imperfect birth canal. Lying always on the same side for sleeping, or propped on the same elbow to read, standing on one foot, one foot on a scooter, one knee in an express wagon are also hard on posture. Some of these habits are hard to break, but if the parents can substitute a better, more comfortable way in a good position the battle is half won.

Fatigue is one of the commonest causes of poor posture. The child seems to be caught in a vicious circle, and it is hard to say whether he droops because he is tired or is tired because he droops. His sitting habits may be the cause, or malnutrition, or flat feet, or trying to keep up with older or stronger children or adults, or insufficient rest and sleep.

If the child is never put to bed as a punishment but always as a privilege the afternoon nap may be continued with great benefit, even after he begins school.

GOOD POSTURE THROUGH LIFE

If children have the good fortune to reach the age of six with good posture, much can be done to preserve it. The school nurse can help the teacher make certain the seats fit them in each grade. Teachers usually ap-

preciate this interest and cooperate as far as possible.

For the child, all suggestions should be constructive and positive, since criticism and nagging are worse than useless. A good example on the part of the parents will help a great deal.

The short, stocky child needs little further supervision, but the tall, slender type requires careful training, especially during periods of rapid growth, with particular attention to nutrition and extra rest.

In the words of Dr. Joel Goldthwait: "The early recognition and proper treatment of conditions which inevitably lead to disease are the most important functions of modern medicine . . . It has become apparent that the most significant part of the work has to do with prevention. Most of the chronic diseases are associated with a wrong use of the body which must have begun in childhood or early adult life. This being the case it is naturally desirable to see that proper training of the body is given *before* the structures have become misshapen or displaced."

What would it mean if our children could be trained from birth to use their bodies with a maximum of efficiency and a minimum of effort?

The study of structural hygiene is truly in its infancy and may some day take its place beside mental hygiene, immunization, and nutrition.

The author's list of references on posture in infants and children is on file at NOPHN headquarters. It may be secured on loan upon request.

Figure 6. Habits in infancy and childhood may lead to deformity.

NURSE AND NUTRITIONIST WORK TOGETHER

CATHARINE LEAMY

In which the two workers again share information and knowledge and reach a practical teaching plan

"WELL HOW IS Mrs. Lacey getting along now, Miss Mason?" asked Miss Seton, the nutritionist, as she and Miss Mason settled down for their conference one month later.

"She's really becoming quite a cook; she actually used some recipes I gave her," replied Miss Mason.

"Which recipes did she try?"

"We discussed a few of the recipes in MONEY SAVING MAIN DISHES[1] which don't require an oven. She liked bean chowder, and also is making cooked cereal with dried milk every morning."

"Have you had a chance to talk to her about fruits and vegetables?"

"No, I put it off—probably because I knew you were going to give me some pointers on those today."

"As I remember it, there were neither fruits nor vegetables other than potatoes on the original menu you described the other day."

"That's right—just fried potatoes! The bean chowder called for carrots and tomatoes so that Mrs. Lacey brought those the two weeks she made the recipe."

"Well, let's start with the vegetables first, then. I suspect that that little country store handles very few fresh vegetables."

"The mothers in this district tell me that the store usually has potatoes, carrots, cabbage. It has turnips, beets, and beet greens once in a while—and that is about all."

"That's certainly not much of a selection, is it! Do the women in that neighborhood pick wild greens—cress, poke, milk weed, dandelions, watercress, fern tops, mustard greens?"

"Yes, haven't you seen them along the roads?"

"No, but I haven't been here very long. Actually I'm not sure just what kinds of wild greens you can find in this country. Here's a bulletin about greens, DELAWARE GREENS[2] do you have a copy?"

"Yes, I use it quite often. I've heard the mothers speak of polk, cress, mustard greens, lambs quarters, as some they use frequently in the spring—and they are enthusiastic about them. Turnip tops, kale, and beet tops are used a good bit by those who have gardens. Mrs. Lacey probably could only get beet tops on the beets she buys at the store."

"How about canned vegetables? Couldn't she buy some of her greens that way?"

"But, Miss Seton, I always thought canned vegetables weren't so good as fresh vegetables."

"But they are! I read about a study[3] which was completed recently on the relative availability and cost of fresh, canned, and frozen fruits and vegetables. It was found that, as a rule, canned fruit and vegetables were

Miss Leamy is regional nutritionist consultant, Children's Bureau, Federal Security Agency.

consistently cheaper and more easily available."

"What about food value?"

"There is little waste of food value in canned foods. When you consider the way in which many women cook vegetables, you would be safe in saying that often canned vegetables have more food value than cooked fresh ones. The very fact that vegetables are taken directly from the fields to the cannery results in less vitamin loss from transportation and storage than may occur in foods bought from the store."

"That is good to know. I'll talk with Mrs. Lacey about buying canned vegetables. I think I could help her a bit on vegetable preparation too—for example, cooking potatoes with the skins on."

"Yes, that is a good point. If our mothers could remember to use a small amount of salted boiling water, and cook the vegetables only until tender, they would save a great deal of the food value and they could use the extra vegetable water in soup or meat dishes."

"How many vegetables should Mrs. Lacey buy during the week for herself and her two children?"

"This chart, FAMILY FOOD PLAN AT LOW COST[1] shows that Mrs. Lacey would need about 6½ pounds of potatoes,—about a pound a day; 6¾ pounds of green and yellow vegetables, and 4¾ pounds of other fruit and vegetables," Miss Seton explained.

"That's certainly too much to carry!"

"If Mrs. Lacey makes daily trips to the store she could plan to buy one of these groups of vegetables every other day. Of course, she would buy an even number of pounds; for example, she might be able to get 10 pounds of potatoes at a better price than a smaller quantity. Then she could carry them over to the next week."

"What about fruits? From what you just said I suppose that canned fruits and fruit juices are often better buys than fresh. Remember the store out there has a pretty meagre assortment of fresh fruits! In the summer the youngsters can pick wild berries, but they can't in the winter."

"You're right," Miss Seton agreed. "Canned grapefruit juice, canned orange and grapefruit juice combined, and canned orange juice are often less expensive sources of ascorbic acid than fresh oranges or grapefruit. She might buy canned apple sauce and canned prunes as inexpensive fruits for variety, but as you know they don't replace citrus fruits."

"You haven't mentioned tomatoes—they're a cheap source of ascorbic acid, too."

"Yes, though it is necessary to use about twice as much tomato juice as orange juice. Canned tomatoes are usually a good buy. Tomatoes help tremendously in adding flavor to inexpensive protein dishes, too."

"To meet her prenatal requirements for iron, Mrs. Lacey will have to use foods high in iron daily. Dried fruit will help, won't it?"

"Yes, dried fruit will help—especially prunes. Often some other dried fruits not as rich in iron are available and relatively inexpensive—dried apples, raisins, and peaches. Apricots are higher in iron, but they usually cost more."

"It is hard to keep track of all these food costs, though, we have so little time to go around getting prices."

"Why don't you write the U. S. Department of Agriculture for FOODS IN PLENTIFUL SUPPLY?[5] It is a monthly bulletin and lists the foods that are apt to be plentiful during a given month. Although these foods are not necessarily cheaper, they are usually available, and may cost a bit less. The list does not apply to this state particularly, but it is a good guide."

"That'll be a great help! How much fruit will Mrs. Lacey have to buy for a week?"

"Well, she'll need 6¼ pounds of citrus fruit and tomatoes. One large No. 5 can of grapefruit juice and 3 No. 2 cans of tomatoes ought to meet her needs," replied Miss Seton.

"In checking this basic seven food guide,[6] we've talked about everything except bread and cereals, butter and margarine, and sweets —I noted when I was at her house that Mrs. Lacey uses enriched bread. She often has sweet rolls, too."

"I am glad to hear that she uses enriched bread, and you mentioned her daily use of oatmeal. Perhaps if the family had more

fruit, the sweet rolls wouldn't seem so important. Dried fruits are a good source of sugars, you know."

"How much bread and cereals would Mrs. Lacey need?"

"Oh, about 6¾ pounds, with oatmeal daily; that is a little more than a pound loaf of bread a day. The money spent for sweet rolls would buy quite a lot more plain bread and cereal."

"Yes, but the Laceys may want them for a treat once in a while."

"That's a good point to remember. Like other folks, they like to have favorite foods sometimes, even if they don't have any special food value."

"How long would a 3-pound box of oatmeal last?" Miss Mason asked. "Ive noticed that's the best buy."

"About two weeks. Does the country store ever have day-old bread? Often you can get that cheaper."

"Yes, sometimes, but only in the morning. Mrs. Lacey is apt to arrive too late to buy it. She's using about 2 pounds of fortified margarine a week. Isn't that too much?"

"Her family needs about 1¾ pounds a week, so that is a bit high," Miss Seton agreed. "Perhaps she could buy a pound every fifth or sixth day, which would make it easier to stretch out."

"We haven't said much about sweets, but I see the chart suggests 1½ pounds a week. The children like bread and molasses and since molasses has iron, I'll tell Mrs. Lacey that that is a good habit to encourage. She and the youngsters are quite fond of sugar—they probably use too much, but we'll have to work on that gradually."

"We must not forget about cod liver oil, either."

"Oh, that's taken care of. Mrs. Lacey gets that through the prenatal clinic enough for both herself and the children."

"How do the meals all add up? Did we get all the requirements in? Let's take a look at a day without meat."

"Here is one, Miss Mason. I've jotted things down as we have talked. Last month we ended with a breakfast of coffee and oatmeal with dried milk, now we'll add citrus fruit juice, enriched bread and margarine. For lunch we had tea, dried beans and cottage cheese sandwiches—now we can add raw cabbage and milk. For supper, we had potatoes, scrambled eggs, milk, peanut-butter sandwiches, and coffee—now we'll add prunes and a vegetable."

"Thank goodness, the children are drinking milk now instead of tea and coffee."

"Mrs. Lacey is pregnant. If she is going to meet her own food requirements, she'll need to be careful about quantity as well as quality."

"Yes, taking the foods we've talked about, for breakfast Mrs. Lacey should have 2/3 cup oatmeal, 1 cup milk, 1 cup grapefruit juice, 2 slices bread, 1 tablespoon margarine. For lunch, she ought to have ½ cup dried beans, ½ cup cottage cheese, 2 slices bread, 1 tablespoon margarine, ¾ cup raw cabbage, and 1 cup milk. For supper 2 potatoes, 1 scrambled egg, ½ cup green vegetable, 6 prunes, 2 slices of bread, 1 tablespoon of margarine, and 3 tablespoons of peanut butter, milk, and cod liver oil."

As Miss Mason rose to go, she said, "This planning together that we've done is going to help Mrs. Lacey, and many of my other mothers, too. It's a good deal to teach, though, in my few contacts with them. I am so eager to get some of them to change their family's diet, that it is hard to keep from telling them everything at once!"

"That's always a problem," Miss Seton agreed. "Food habits are so complex that changing them is usually a slow and difficult thing to do."

"Of course, I already have Mrs. Lacey's interest to build on and I have succeeded in helping her use more milk for herself and her family. I've really made a beginning. I think a pretty good beginning."

"You certainly have, Miss Mason, and the fact that Mrs. Lacey is pregnant will give her an added incentive to continue working on her family diet," agreed Miss Seton.

"Of course, we have had to plan very carefully, since Mrs. Lacey has such a small amount of money for food. It just isn't

adequate. We haven't said a word about how we can fit tea, coffee and seasonings into the budget, nor allowed for variety. And still our planned order is already a little more than $35. I do hope the Welfare Department will be able to increase the allowances soon."

"I hope so too."

"Now that I have all of these facts, I'll plan to take up one or two with Mrs. Lacey every time I see her. Then I'll check on and encourage her to continue with the better diet for herself and her family considering those points we discussed before. How do you think that would be?" asked Miss Mason.

"That is excellent! This kind of teaching takes long-time planning, patience, and satisfaction with small gains, but it is worth it!"

"Yes, and you get a big kick out of really helping these families improve their diets. You really do. I guess that's why one keeps on with the job. You get a feeling of being useful to other people. I'll probably be back next month with another problem. Problems are what I have plenty of," Miss Mason said laughingly. "Goodbye for now."

"Goodbye, Miss Mason, and come again."

This is Part II of "Nurse and Nutritionist Work Together," in two parts. Part I appeared in January.

REFERENCES

[1] Money saving main dishes, AIS 69, U. S. Department of Agriculture, Office for Food and Fuel Conservation, Washington, D. C.

[2] Delaware greens. Delaware State Board of Health, Dover. 4 p.

[3] Krehl, W. A. and Cowgill, George R. Comparative cost and availability of processed fruits and vegetables, *Journal of the American Dietetic Association*, 1948, v. 24, p. 304-310.

[4] Family food plan at low cost. Preliminary Miscellaneous Publication 662. U. S. Department of Agriculture, Bureau of Human Nutrition and Home Economics, Washington, D. C., September 1948.

[5] Foods in plentiful supply. U. S. Department of Agriculture, Production and Marketing Administration, Washington 25, D. C.

[6] National food guide. AIS 53, U. S. Department of Agriculture, Bureau of Human Nutrition and Home Economics, Washington, D. C.

ON YOUR ICN TRIP TO SWEDEN

FOR THOSE OF YOU who are planning to attend the ICN Convention in Stockholm, Sweden, in June 1949, here are a few suggestions. Take plenty of your favorite American brand of cigarettes if you smoke. Although Sweden is endeavoring to approximate the American blend, you will want your own. Take along a few bars of a common American floating soap. A few pounds of coffee and a few packages of rice will help you with that extra cup of coffee in a land where coffee is idolized but severely rationed. And if you wish to show your appreciation to your hosts, a gift of coffee or rice will do the trick. Take along your camera and some rolls of film, although you will find fine film service throughout Sweden. Convert your money into traveler's checques for then you may carry into Sweden unlimited amounts, but you will find there is a definite limit on the amount of currency allowed. If you search out the American Express Company's office in Stockholm (it is around the corner from the Hotel Stockholm), you will be able to get your checks cashed at face value rather than at the daily dollar market quotation.

In Sweden itself, you will find that the tip to a waitress in a restaurant, a Konditori or cafe, is 10 percent of the bill. This is established by law. A restaurant serves full meals

and liquors by the drink. A Konditori serves Swedish cookies and cakes with coffee or chocolate by the drink. A Mjölk Bar is a cafeteria and, as its name implies, serves milk. The motion picture houses have two showings nightly, and seating after a performance has begun is not customary. Seats are usually sold reserved, and may be bought in advance. However, if you like Mickey Mouse or Charlie Chaplin, there are several houses showing these which operate on American principles. Above all, don't worry about not being able to speak Swedish; so many of the folks there speak English either well or "of a sort."

Those interested in sightseeing and learning something of Swedish public health nursing education and service will discover that the school for Sweden's public health nurses is located in the beautiful new buildings of the Statens Institut för Folkhälsan among the evergreens on the granite slopes of Tomteboda not far from Karolinska Hospital.

American nurses will surely want to make the 20-minute journey by streetcar from the city center to the Institut. They will find the nursing school housed in the Institut along with the schools for sanitarians, inspectors, and health officers. Laboratories where experimentation is carried on in industrial hygiene, water, air, and food studies occupy other parts of the building and supplement the lecture and field demonstration courses.

The students are for the most drawn from all parts of Sweden but there are usually several from Iceland, and others who understand the Swedish language may be admitted. All classes are conducted in Swedish. The faculty, however, is well acquainted with America and American methods. Occasional study visits and attendance at conventions have been augmented by institutional training and work in school and hospitals in the United States. Miss M. Tjellström directed the school in 1946.

Studies lead to district nurse and district supervising nurse. Courses are essentially the same as an American nurse takes to become a public health nurse in an American school. Basic courses include hygiene and physiology, bedside nursing, epidemiology, and environmental sanitation. Like the American, the Swedish student nurse is assigned to a nearby health unit for field work, reporting back for her lectures and assignments.

Except for general classes in hygiene or sanitation, the nurses and other students keep strictly to their own courses. The health officers who are called in for refresher courses never sit with other students but meet with the director of the nursing school or her representative for a session where she gives them the district nurse's view of public health work and opens the meeting for a discussion of mutual problems. In 1946, opportunity was given for a rebuttal session after graduation, so perplexing were the problems and keen the interest. Activities at the Institut center about the auditorium and several adjacent classrooms.

American nurses will find these Swedish nurses and students sincere and hard-working, intelligent and capable. As Swedish nurses comment on the trim slenderness of the little American nurse, so will she comment on their more robust look. She will come away with a feeling of respect for the lovable women in the dark grey uniform suits that reach almost to the ankles—in 1946 there was a rebellion among Swedish nurses about wearing the uniforms both on and off duty—and for their show of democracy and their pursuit of equal rights and better conditions.

Visiting Americans should note the strategic placement of the Institut near the Karolinska Hospital, the Tomteboda Blind Institut, the Children's Orthepic Hospital (Vanförsanstalten), and other private and public care agencies. These are among the many demonstration areas used by the Institut to show the up-to-date accomplishments of social medicine.

IVAN B. O'LANE, M.P.H.
Seattle, Washington

A COLLEGE HEALTH PROGRAM

GAYLE POND, R.N.

DURING THE WAR YEARS college health services were forced to make many changes; some were curtailed or almost completely abandoned, while others were greatly expanded. In the shift to present conditions, colleges and universities have found it necessary to evaluate and reorganize their health programs. The greatly increased enrollments, due to the veterans' training program, have helped accelerate the process, and in some ways made it easier to effect needed changes. Dr. Ralph Canuteson has described the situation: "Encouraging numbers of schools are starting new or completely reorganized health programs. These generally are being built along prewar patterns, but with the elimination of obsolescent ideas and with the addition of new services. . . . Shifting personnel is bringing into the field younger men and women. They may not possess the advantages of long experience in health services, but they have enthusiasm, undulled by years of pushing against an inertia of disinterest in public health."

The National Organization for Public Health Nursing recognizing the need for discussion and study of this important field of health work, suggested that a review of the policies and procedures employed in a medium-sized institution such as Western Michigan College might be of general interest. In making the report, we realize that, under the present over-crowded conditions, there are many needs and interests of students for which the program is inadequate. The health service staff, with the assistance of the college health committee, and the active support of the administration, is continually trying to evaluate the work and to develop a dynamic and expanding program.

Western Michigan College of Education is located in Kalamazoo, and is one of eight state-supported institutions of higher education in Michigan. It has an enrollment of 4200 students, which is approximately double the prewar number. Since this same overcrowded situation exists on nearly every college campus today, many of the problems we have had to face will sound familiar to other college health workers.

The college infirmary and many of the other facilities had been reserved for the use of the Navy during the war, therefore, when the service units were withdrawn and the veterans returned to the campus in increasing numbers, it was necessary to review and reorganize the health service activities. While this was being done, to insure close cooperation of all departments concerned with student welfare, members of the health service staff held numerous conferences with the deans, the guidance department, physical education directors, and the administration. After the policies were checked and approved, printed copies were distributed to the faculty and students. Additional publicity was given

Miss Pond is director of the Student Health Service, Western Michigan College of Education, at Kalamazoo.

through bulletin board displays, and the policies were printed in the school paper.

Briefly, the material covered in these policies and procedures is as follows:

1. The health office—under this heading, the work of the out-patient clinic was described. The names of the doctors, dentist and their office hours were stated, and special clinics listed.

2. The college infirmary—types of cases, terms of admission, and daily charges were given.

3. Service of physicians outside of regular clinic hours—the physician is available, but the expense must be assumed by the student.

4. Absences due to illness—these must be reported to deans' offices before 9:00 a.m. and student is then asked to report to the clinic for advice and treatment.

5. Physical examinations—the rules and regulations are stated regarding entrance examination, for physical education activities and competitive sports. Students are urged also to report for an examination whenever they are concerned regarding their physical condition.

6. Physical education schedules—the requirements in this field were stated, and a reference made to the special program available for the physically handicapped.

7. Chest x-ray examination—annual chest x-rays are required of all students and food handlers. A special clinic is arranged in cooperation with the state department of health. Faculty and employees are urged to take advantage of the service.

8. Immunization program—the student health history contains a record of these, and he is urged to seek professional advice if he has not had recent immunizations.

9. Student responsibilities—it was felt that a brief statement of certain cardinal health principles should be included.

10. Emergencies—this was a brief statement of how and when to seek aid in case of emergencies arising outside clinic hours.

11. Faculty and staff—although our health service is primarily for students, and partially supported by student health fees, the faculty and staff are urged to feel free to come to us at any time in case of emergencies, such as a sudden illness or accident which may occur on the campus.

In order that the work with the students be as uniform as possible, many staff conferences were held, standard hospital and clinic procedures were studied, and a detailed set of standing orders prepared. These outline the daily routine care of patients, technics for giving special treatments, maintenance of supplies and equipment, cumulative records, and other procedures. The orders covering the care of minor illnesses and first-aid procedures were approved and signed by the college physician, who assumes the responsibility and supervision of all the medical work carried out by the nurses in the clinic and infirmary.

The general work of the health service follows the usual pattern. It includes the entrance physical examinations of all new students; the annual examination of food handlers; and re-examinations for students in strenuous physical education activities, competitive sports, and where there is any question regarding a student's health status.

The annual chest x-ray clinic, which is scheduled in the early fall, is conducted in cooperation with the mobile unit from the state department of health. And arrangements have been made for a close follow-up program on questionable chest conditions at the local tuberculosis hospital.

In addition to the routine care of minor illnesses and first-aid work, the clinic maintains a laboratory and x-ray department. These are invaluable in making preliminary examinations. However, if some serious condition is indicated, the patient is sent to a local hospital, or professional laboratory, for a complete diagnostic study. In case a surgical operation, or some major work such as the application of a fracture cast, has been necessary the patient may be brought back to the college infirmary for the convalescent period.

Special services are available to the students: in the dental clinic, which is held twice a week; in a semi-monthly skin clinic, under the direction of a dermatologist; and with a

psychiatrist, available by appointment. Some of the physical education instructors are registered physiotherapists, and a limited amount of such specialized treatment is available. The speech correction and psychoeducational departments offer rich resources for a better understanding of the student, and are an invaluable part of the total health program.

The health service works very closely with the physical education departments. The results of physical examinations, with the physician's recommendations, are transmitted immediately to these departments, and frequent conferences are held to discuss policies and procedures in connection with any unusual condition which may arise. This important phase of the health service is facilitated by scheduling the needed physical examinations of upper classmen at the beginning of each new sports program. For example: the fall football practice starts before the beginning of the school year, and a special clinic is scheduled to examine these men at that time. The needed information, therefore, is not delayed by the mass examination of new students during Freshman week. In the same way, the basketball, track, and baseball squads, the physical education majors, and swimming classes are reexamined at appropriate intervals throughout the school year.

The health service staff also cooperates with many other departments in the college, such as, the guidance department, the deans of men's and women's activities, and the administration. If there is a question regarding a student's physical ability to carry a full academic load, to participate in heavy extracurricular activities, or to pursue part-time employment, this information is relayed to the proper department. A member of the staff works with the Scholarship Committee, so that health, as well as other factors, can be considered in trying to determine the reason for a student's inability in making a satisfactory adjustment to academic life.

Public health problems, such as housing conditions for students, the safety and sanitation of buildings, college cafeterias and soda bars, are referred to the health service. Valuable assistance is rendered by the city health department in making surveys and recommendations. They also supplement the college laboratory service by making detailed examinations of throat cultures, sputum, and blood specimens.

The unusual question of health supervision and a nursing service for students' families became a problem of concern for the college health service in the postwar period. This was solved by a cooperative plan, whereby the college furnished the space and some of the equipment, the Office of Veterans' Affairs provided financial assistance, and the professional services were supplied by the city health department.

The volume of administrative detail necessary for the operation of a college health service consumes much of the director's time. Conferences with coworkers and with other departments in the college, scheduling and directing the special clinics, checking records and writing reports, buying supplies and equipment, and supervision of housekeeping activities, absorb a great deal of time. The normal changes in professional personnel, as well as the fact that students are employed in a number of part-time positions requires considerable staff supervision.

Until the present year, in addition to the clinic and infirmary work, the college nursing staff had been responsible for teaching several units, namely, the Red Cross Home Nursing classes given for the home economics and rural education students. The staff was called upon also, to take part in educational laboratory and guidance classes, when health subjects such as mental hygiene, health education and the school health programs were under discussion. One nurse was assigned to supervise the health program in the campus training school, to counsel the nursing students on campus, and to act as coordinator between the Bronson Hospital Training School and the college. In order that this important phase of the work could be given the time and attention it deserved, a separate division of nursing has been established, and all of the classroom teaching that was formerly done by the health service staff has been transferred to it.

The question of adequate health education for all students, and special training in the subject for prospective teachers, has been of great concern to educators for many years. Dr. Alexander Ruthven, president of the University of Michigan, has taken the schools sharply to task for their failure to develop sound programs of health education, saying, "Since we cannot give our students all of the knowledge they will need for the rest of their lives, relative values should be considered, and some of the less important offerings should be sacrificed for more adequate instruction in the art of keeping well. In the battle of the curriculum, this is an important and too long overdue engagement."

Western Michigan College has been represented at numerous local, state and national conferences on health education, and representatives of the health staff have assisted in various studies of school health work. This writer feels that such conferences and surveys are invaluable to all health workers who are striving to develop and administer successful health programs in colleges and universities.

NATIONWIDE CIVIL SERVICE EXAMINATIONS FOR PUBLIC HEALTH NURSE

The U. S. Civil Service Commission has announced an examination for Public Health Nurse, for filling positions in the U. S. Public Health Service and the Indian Service, located in Washington, D. C., and throughout the country. A few positions in the territories and possessions of the United States may also be filled. The salaries for the positions are $3,727 and $4,479 a year.

No written test is required in this examination; applicants will be rated on the basis of their education and experience. To qualify, they must have completed a 3-year nursing course *or* a 2-year nursing course plus appropriate nursing experience or education. Included in or supplementary to this education, applicants must show a minimum of 30 semester hours in an approved program of study in Public Health Nursing. In addition, they must have had a minimum of one year's experience in public health nursing in a generalized community public health program. For positions paying $4,479, additional experience in staff nursing or supervisory experience is required. All applicants must be currently registered as professional nurses in a state, territory, or the District of Columbia, at the time of appointment.

The maximum age limit for positions paying $3,727 in the Indian Service is 40 years; and for all other positions to be filled from this examination, 62 years. These age limits are waived for persons entitled to veterans preference.

Further information and application forms may be obtained from the U. S. Civil Service Commission, Washington 25, D. C., from most first- and second-class post offices, and from Civil Service regional offices. Applications must be received in the Commission's Washington office not later than March 29, 1949.

THE GLAUCOMAS

PETER C. KRONFELD, M.D.

THE EYE diseases comprised under the term "The Glaucomas" still constitute a major medical and public health problem in the United States. The nature and magnitude of the problem is revealed by the following facts:

1. The incidence of the glaucomas in the population is slightly greater than 1 percent in individuals over 35 years of age and increases with increasing age.

2. The glaucomas represent a very heterogeneous group of diseases the members of which vary widely as to cause, mechanism, and symptoms.

3. The majority of the glaucomas take a course characterized by gradual, insidious and entirely painless loss of peripheral vision of which the affected individual usually does not become aware until it has reached very major dimensions.

4. Most forms of visual loss due to glaucoma are irreversible; medical or surgical therapy, if successful, only arrests but does not cure the disease.

5. Of the approximately 120,000 citizens which are blind in both eyes, about 30,000 are blind as the result of glaucoma.

The one feature that all glaucomas have in common is the progressive loss of visual function attributable to a state of abnormally high pressure within the eye. The injuriousness to the delicate ocular structures of a state of abnormally high intraocular pressure is readily understood.

Dr. Kronfeld is professor in ophthalmology, Illinois Eye and Ear Infirmary, School of Medicine, University of Illinois.

A short detour into the mechanism of normal intraocular pressure is unavoidable at this point. For the eye as an optical instrument stability of shape and form is essential. Nature has solved this problem by providing an only slightly distensible fairly stiff outer coating, the sclera and cornea which are kept distended by the intraocular pressure.

The normal intraocular pressure range is between 15 and 28 mm. of mercury. Its height depends upon the relationship between the elasticity of the eyeball wall which remains constant and the volume of its contents which is variable. There are two fluids, the blood circulating in the intraocular blood vessels, and the specific tissue fluid of the eye called the aqueous humor. According to prevailing concepts the aqueous humor is produced by the gland-like ciliary body, circulates through the chambers of the eye and leaves it through a delicately constructed safety valve located at the angle of the anterior chamber. The height of the intraocular pressure would thus depend on (1) the amount of blood present in the intraocular blood vessels (2) the rate of production of aqueous humor and (3) the rate of outflow of aqueous humor.

In the large majority of the glaucomas the mechanism of the elevated intraocular pressure is a disturbance of the outflow of aqueous

humor due to obstacles to the aqueous circulation within the eye. In other cases the site of the disturbance is at the source of the aqueous, the ciliary body having gone into a state of hyperactivity.

The salient facts about the glaucomas have been known to the medical profession for the last three to four decades. The logical consequence of this knowledge has been the general realization that the glaucoma problem can be tackled and the visual, economic and social damage done by the disease can be alleviated or reduced by two main approaches, namely *earlier diagnosis* and *more effective therapy*.

EARLIER DIAGNOSIS depends on as general a knowledge and understanding of the symptoms of the glaucomas as can be conveyed to and utilized by all persons whose profession it is to take care of the eyes of the nation. The multiformity of the glaucomas mentioned before makes it difficult to describe all the symptoms within the limits of a single article. However, the writer believes that a practical understanding of the symptomatology of the glaucomas can be acquired by familiarizing oneself with three of the numerous variations in the course and subjective symptoms of the glaucoma. Before these three characteristic variations can be appreciated it is important to realize that glaucoma often follows in the wake of many ocular diseases which through their location at or near the critical points in the bed of the intraocular fluid stream, are apt to interfere with the fluid circulation and thereby give rise to an elevation of the intraocular pressure. Glaucomas of this type are called secondary because they are secondary to other, pre-existing ocular diseases. Such secondary glaucomas are common developments in eyes with chronic inflammation of the iris, in eyes harboring a neoplasm, and in eyes in which the venous blood flow has become embarrassed by thrombosis or vascular sclerosis.

Glaucoma also appears as a primary disease where no pre-existing ocular disease has been known and is therefore called primary.

NOW LET US turn to the three main variations in the clinical course of the glaucomas.

1. ***Mild, recurrent, self-limited attacks.*** This course of glaucoma is most widely known and most easily recognized. States of elevated intraocular pressure occur only during a small fraction of the affected person's waking hours and the change from normal to elevated pressure and back to normal is rapid so that most affected persons cannot help becoming aware of the abnormal, disturbed state of their eyes. Most characteristic subjective manifestation of the elevated pressure is a specific type of visual disturbance, namely the appearance of grey or colored rings around small sources of light. Patients who are familiar with the phenomenon test themselves by lighting a match and looking at it from a distance of two feet. Street lights viewed through the steamy windshield of the automobile appear to the normal eye just like all light sources do to the glaucomatous eye during the attack. Distance vision as measured on the Snellen chart is diminished during the attacks, but of this visual impairment the patient may not become as aware as he does of the haloes around lights. In a considerable percentage of cases in which glaucoma takes the course of recurrent mild attacks, the latter are associated with a mild eye-ache or headache. The attacks occur at irregular intervals and with varying severity and duration. An investigation into the circumstances under which the attacks occur, reveals a preponderance of situations in which the patient is exposed to dim light or darkness, aggravated by worry or mental anguish. To imitate these situations the ophthalmologist subjects patients suspicious of this type of glaucoma to the darkroom test which consists of determining the effect upon the intraocular pressure of exposure to darkness for one hour.

As time goes on, the attacks characteristic of the course of glaucoma under discussion usually get more frequent or more severe. The disease is thus characterized by a slowly progressive course. Permanent damage to peripheral vision is done during each attack, at a rate depending upon the severity of the

attacks. Most patients, fortunately, seek medical help before a great deal of vision has been lost permanently. In many instances the patient is forced to do so because of the development of one severe acute attack which does not terminate by itself.

2. *The severe acute attack* may be described as a more severe, more dramatic form of the attacks described under (1) and may set in as the culmination of attacks of the latter type. In other cases the acute attack develops "out of a clear sky." The essential fact about severe acute attacks is that very few of them subside by themselves and that they are very injurious to the eye. Every hour, if not minute of such an attack entails a measurable amount of permanent visual loss and permanent serious derangement in the structures of the eye not directly concerned with vision. The severe acute attack therefore represents a true ophthalmological emergency in the sense that it should be attended to now and not tonight or tomorrow.

The symptoms of the acute attack are those of the milder attacks, but with very much greater intensity and extensity. The impairment of vision is so severe that the patient may not be able to count fingers at a distance of three feet. This visual impairment is largely due to cloudiness of the cornea resultant from the elevated pressure. At this low visual level the patient may not be aware of any haloes around lights. The other cardinal symptoms of the attack are ocular pain radiating into the neighboring parts of the head and face and nausea and vomiting. For reasons that are not entirely understood, in some patients the visual impairment, in others the local pain, and in still others the gastro-intestinal upset is the predominating feature of the acute attack. Cases of the latter type have been mistaken for primary gastro-intestinal diseases.

Evaluation of the objective eye symptoms of such cases is not easy because of the steaminess of the cornea that precludes examination of the deeper structures of the eye. If the position of the iris can be estimated with reference to the cornea, one notices a narrowness of the space between the two structures, a narrowness which is also present in the patient's other, seemingly unaffected eye. The affected eye feels "hard as stone" if it is palpated through the upper lid, and there usually is marked congestion.

3. *The chronic insidious course of glaucoma* represents the other extreme in the polymorphic clinical pictures produced by glaucoma. Without any discomfort, ache, congestion or other form of warning a gradual, but characteristic loss of peripheral vision occurs, with one eye usually a little ahead of the other. The rise in intraocular pressure occurs so gradually that the blood circulation of the eye can adapt itself to a new pressure level. Under these conditions only the structures directly concerned with vision, the retina and the optic nerve, deteriorate while the other structures of the eye continue a fairly normal existence.

The progressive deterioration of retina and optic nerve takes a characteristic course. The central vision, that is the faculty to recognize the letters on the Snellen chart, to read small print, to sew, knit or embroider, remains uninvolved for a number of years. Certain peripheral portions of the field of vision become victims of the disease before the center is attacked. To appreciate the glaucomatous field loss one has to remind oneself of the existence and value of the normal field of vision which is the section of the outside world that is imaged on the retina and thus visually embraced by the non-moving eye. Just like each shot of the photographic camera yields an image of a considerable section of space, the human eye fixating upon a point straight ahead embraces a considerable section of the world. The expanse of this section is measured by the angle that the most eccentric object perceived subtends with the line of vision. Observation of our own monocular field of vision tells us that expanse toward our temple ("on the temporal side") is greater than 90 degrees of arc whereas in all other directions (nasally, above and below) the field extends about 45 degrees into the periphery. Another instructive observation that we can make on ourselves is the presence of the normal blind spot in our field of vision.

With the left eye covered our right eye fixates upon a black dot on a white sheet of paper held at a distance of one foot from the eye. Another small black object such as a pin with a black head, disappears completely if placed about 2¾ inches to the right of the point of fixation which is the approximate location of the normal blind spot in field of vision of the right eye.

THE GLAUCOMATOUS field loss characteristically starts in the upper-nasal sector of the visual field. Such field defects often remain unnoticed until the patient or his doctor takes a visual inventory of each eye separately. The main reasons why these defects go unnoticed for a long time are (1) that the upper-nasal field sector is not very important for visual orientation,—that is, for walking about, crossing a street, or driving an automobile and (2) that the particular section of the outside world is covered by the upper-temporal field sector of the patient's other eye which, as a rule, falls victim to the glaucomatous process much later than the upper-nasal sector, and (3) that the glaucomatous field loss in the type of glaucoma under discussion is too slow to give the patient the impression of any abnormal goings-on.

A case report may serve to illustrate these points. I have had under my care Mrs. I. R., present age 81, with a bilateral far advanced glaucoma of the insidious type. During the last three years I have examined this lady three to four times a year. Each examination has included the careful, painstaking measurement of the small, remaining portion of the visual field. At each visit to my office the lady was accompanied by her younger sister, Miss L. H. age 71, who has shown great interest in her older sister's condition and has been a witness to every visual field and other tests done on her sister's eyes. Recently the younger sister asked me to check her eyes. I found an early glaucoma of the insidious type in both eyes with a complete loss of the upper nasal field quadrant in one and a lesser defect in the other eye. Both patients belong to the intelligentsia and have, at least for the last three years, been living in an atmosphere of awareness of the glaucoma problem. The younger one has been and still is driving an automobile. This case is an interesting example of the inconspicuousness of the early glaucomatous field changes even to a glaucoma-conscious person.

After the upper-nasal field sectors have been destroyed, glaucoma usually "goes to work" on the lower-nasal quadrants. From there the process of destruction moves on to the temporal (lateral) portion of the field. The central area is very resistant to the glaucomatous process and may hold out for several years despite high intraocular pressure. Patients with such small central field islands are still able to read fine print and perhaps even 20/20 on the Snellen chart. They get around reasonably well in their homes where they are familiar with the layout and the position of every piece of furniture. In city traffic however they are in constant danger because their eyes embrace only a very small section of the world. These patients miss steps, bump into other pedestrians, lampposts and signposts, and are "lost" in heavy traffic. At home at their desk or in their favorite chairs their vision may be good enough for prolonged constructive close work.

As the disease progresses the constriction of the visual field becomes more handicapping and noticeable to the patient. Treatment instituted at this stage, even if it succeeds in lowering the intraocular pressure, does not alleviate the patient's visual handicap. Under the most favorable conditions treatment for chronic glaucoma accomplishes only an arrest of the disease and not a restitution of any of the visual loss present at the time the treatment was instituted. Earlier diagnosis of chronic glaucoma must therefore be the keynote of any move aiming at a reduction of the amount of blindness caused by glaucoma, and earlier diagnosis is only possible by conveying a state of practical awareness of the glaucoma problem to all personnel that come in medical contact with large groups of the adult population. While no age or race group is immune to glaucoma, primary chronic simple glaucoma is characteristically a disease of individuals over 40 years of age. For that reason most ophthalmologists include in the routine eye examination of all patients over 40 years of age one or two specific tests for chronic glaucoma. The large majority of the population, however, does not consult an ophthalmologist during its whole life. Earlier diagnosis, therefore, requires the active participation in the case-finding program of non-

ophthalmological personnel. In a previous publication addressed to internists and general practitioners* I have stated that it "does not seem too difficult or too laborious to include in every complete physical examination a test or two that would exclude the presence of advanced glaucoma. A peek at the patient's eye ground with the ophthalmoscope, a rough determination of the visual acuity with the patient's glasses, and a rough field test by the confrontation method (described later) would seem adequate and at the same time not too time-consuming or difficult. Such a program would not only be very much in the interest of the patient and his dependents but would also be of great value to the patient's employer, to the insurance company, and the physician who share the responsibility for the patient's well-being."

The purpose of the paper quoted was to solicit the help of internists and general practitioners engaged in mass physical examinations in business, industry, or for insurance companies.

THE IDEAL and probably most effective form of case-finding is by means of mass surveys conducted by ophthalmologists with the specific purpose of detecting early chronic glaucoma. Such a survey has been conducted on department store and insurance office employees by the Philadelphia Committee for the Prevention of Blindness. The diagnostic tests were made by eye physicians. Of 2,400 persons examined 1.3 percent were found to have chronic glaucoma. It is to be hoped that in the near future more and more groups of the population will receive the benefit of such specific mass surveys. Obviously it will be difficult to conduct such studies on the rural population.

A simple but crude way of estimating the extent of the visual field is by using the examiner's hand as the test object and the examiner's visual field as the standard (the so-called confrontation test.) The examiner seats himself directly in front of and at a distance of about three feet from the seated examinee. The latter covers his left eye and focusses his right eye on the left eye of the examiner who in turn covers his right eye and focusses his left eye on the examinee's right eye. In a plane about half way between examinee and examiner the latter moves his hand slowly from the periphery toward the center of the visual field. The examinee is requested to speak as soon as he notices the appearance of the hand in his range of vision. If the latter is normal, he and the examiner should notice the appearance of the hand in the same position, that is at the same time.

The method permits the recognition of the large field losses characteristic of advanced glaucoma. More exact measurements can be made by means of a blackboard or a black screen placed at one to two feet from the seated examinee. The latter again covers one eye and focusses the other on a mark in the center of the screen. A pin with a white head or a white paper disc mounted on a dark stick serves as a test object. The point at which the approaching test object is first noticed to appear by the examinee is recorded with pencil or chalk on the screen and compared, afterwards, with the point at which the examiner, placing himself in the same position, first notices the test object.

It does not require any unusual power of observation to notice the presence or absence of gross restrictions of one's own field by placing oneself with one eye closed in a suitable and easily reproducible position at the office or at home and "taking visual inventory" of all the objects that the other eye can see, letting only our attention but not our eye wander along the border of the field.

In interpreting field findings in older people it is important to remember that the two common types of visual disturbance in older people, senile cataract and senile or vascular retinal degeneration, do not produce visual field defects similar to the glaucomatous ones. Senile cataract does not cause any circumscribed field defects and the senile or vascular degenerations of the retina may affect its very center, leaving the peripheal field intact.

---

* Kronfeld, P. C. Preventable blindness, *Journal of the Michigan State Medical Society*, March 1944.

THE FACT that the major portion of this paper has been given to measures designed to bring about earlier diagnosis of more of the existing chronic glaucomas, will make the reader aware of the significance of such measures. Early diagnosis, however, is not the only problem pertaining to the glaucomas. Even in some of the early diagnosed cases it happens that medical and surgical treatment by experts fails to avert the tragic outcome of total blindness. Ophthalmologists have been and still are striving to improve the existing methods and, specifically, to determine the causes of failure of glaucoma operations in certain cases. Progress has been made during the last decade as the result of the establishment of glaucoma clinics in some of the large cities. These clinics are intended primarily to provide special diagnostic and follow-up facilities for glaucoma patients. The observations made and the information gathered in these clinics has already exerted a profound and apparently beneficial influence upon the guiding principles in the treatment of the glaucomas.

Most glaucoma patients have to remain glaucoma patients for the remainder of their lives. Even the most perfect operative result or the most satisfactory response to conservative treatment needs to be checked at varying intervals. In this respect glaucomas have to be treated very much like cases of diabetes whose diet and hormonal medication has to be adjusted to the endogenous fluctuations in the severity of the disease. Most cases of glaucoma require follow-up examinations consisting of measurements of the visual acuity, of the visual field, and of the intraocular pressure. A good portion of this work can be done by nurses trained and equipped for such work in the field. Portable instruments for accurate field and vision tests are available. An adequate mobile outfit would not take up more than half of an ordinary trailer. Plans for such follow-up work conducted by nurses at the request of and under the supervision of ophthalmologists are being considered by several agencies in this country. With the return to peacetime conditions not too far off, it is hoped that the facilities for follow-up work will improve materially during the next decade.

1949 CHEST CAMPAIGNS

More than one third of 300-odd chest cities not only reached their 1949 goals but went beyond last year's totals, states Esther Moore in the January 1949 Bulletin of Community Chests and Councils of America. Another third did not reach their goals but beat 1948 totals. A further small group reached their goals even though the amount was not greater than last year. A seventh neither reached their goals nor raised more money than last year. Because of this confusion, statistically speaking, between desired goals (many communities set their figures high as representing all they would like if they could get it), the amount actually raised, and their comparison with what was raised last year, it is hard to generalize about the success or failure of the 1949 campaign. However, the record achieved is basis for facts such as the following:

1. The chests tried hard to meet rising costs by setting goals averaging 13 percent higher than amounts raised in 1948.

2. About half the chests so far reporting achieved the increased goals; three fourths raised more than last year.

3. With all returns in the total will probably stand at $185,000,000, the largest for any year except for the period when the National War Fund added an extra one third to the results.

4. A significant number raised more this year than ever before.

GLAUCOMA: A PROBLEM FOR THE PUBLIC HEALTH NURSE

HELEN E. WEAVER, R.N.

GLAUCOMA is a serious yet common eye disease occurring most frequently in people over 40 years of age. It is characterized by increased pressure within the eye to a level at which it is unable to maintain normal structure and function. Unfortunately, the early symptoms are often mild and go unnoticed. Because of its quiet onset, the recognition of the disease is often overlooked and, by the time the diagnosis is established, the time at which help might have been given most effectively has long since passed. A thorough knowledge and understanding of the symptoms of glaucoma are essential to the nurse who is doing case finding. The three main variations in the clinical course of glaucoma, as described by Dr. Kronfeld, will help the nurse understand the wide variations in symptoms that do occur and the reasons why so many patients are vague about their symptoms.

Glaucoma causes about 12 percent of blindness in adult life. In addition to the persons who are totally blind because of glaucoma, there are many persons whose vision is so impaired that pursuit of their usual occupation and activities is impossible. Many persons, too, lose the sight of one eye. It is said that 60 to 80 percent of the cases of total blindness from glaucoma need not occur if the diagnosis is established early and if the patient follows his treatment routine assiduously. It is this hopeful factor which makes glaucoma a public health problem and a problem in which every public health nurse has a real responsibility and a real task to perform.

If total blindness of the individual is to be averted and sight is to be retained, then early medical diagnosis and care must be secured. Securing medical diagnosis and care is not a new procedure or undertaking for the nurse but a rather familiar procedure toward which the nurse directs her activities in tuberculosis, maternity, and communicable disease nursing, as well as in many other conditions.

The skills and technics which the public health nurse has mastered in helping the patient obtain care in these conditions will help her here. She will need to train herself to recognize and become alert to the many vague symptoms and complaints which the patient presents and which oftimes the patient himself regards as meaningless. The nurse will need to develop a high index of suspicion to these varied and mild symptoms and use these to motivate the patient to seek medical care, while at the same time avoiding overanxiety and worry to the patient. Most persons are reluctant to seek medical care but may express a wish "to wait" on the supposition that "time is a great healer" or "ignorance is bliss." Many times, too, because of family history the person fears blindness and doesn't want his suspicions verified. The nurse must remember that in an acute attack of glaucoma even a few hours of waiting may be too late to save the eyesight, and she will need to use her most persuasive influence in helping the person

Miss Weaver is consultant in nursing activities, National Society for the Prevention of Blindness, New York City.

seek medical care at once. Her responsibility, however, does not end at the time when medical care is obtained nor at the time when the diagnosis is established.

Mass surveys of selected groups of the population are suggested as a case-finding device by Dr. Kronfeld. Here again the public health nurse can assist immeasurably in stimulating such surveys and arranging for their undertaking.

OPPORTUNITIES FOR TEACHING

Patients with glaucoma—as with other chronic diseases—are confronted with the problem of long-time and often expensive medical care. Here the nurse has a two-fold function—especially in a rural area where medical social workers are not available (1) of helping the patient accept the established diagnosis and (2) of helping the family accept the total situation. This again is not an unusual situation for the nurse, but here she must be familiar with the personality problem, the behavior pattern, and the unusual reasoning which the glaucoma patient will present.

The patient is faced with the probability of having to use drops in his eyes for the remainder of his lifetime and with the possibility of repeated surgery as well as the fear of blindness with its social and economic dependence. Thus, the patient himself presents unlimited possibilities for teaching. He will need to be taught to administer the drops correctly so as to receive the utmost help from them. Hot applications or massage are also often used and the patient must be taught to do these as well as to understand their place and value in the total scheme of treatment. The nurse's teaching must be so highly motivating and the learning on the part of the patient so complete that there will be no delay in either carrying out treatment or keeping medical appointments.

In addition to the actual treatment there must be an effort to find a variety of activities which the patient can safely pursue. It is a recognized fact that the emotional factors play an important role in bringing about the complete recovery of the patient and that exaggerated emotional response, such as undue excitement and hilarity as well as excessive worry or sadness, retards the progress of recovery.

If surgery is to be performed the patient should be adequately prepared for this experience. Remember the patient with eye surgery frequently must lie flat with eyes bandaged, and he may have to remain in darkness in unfamiliar surroundings for days.

It is especially helpful to have the patient who is to have surgery clearly understand the preparation for operation, procedure following operation, and the need for his complete cooperation. He should be given every opportunity to ask questions, and these should be adequately and concisely answered.

At the same time the public health nurse should work closely with the family, being certain that they too are kept informed of the plan of treatment and what it entails. They will need suggestions and help in finding diversified activities for the patient during his convalescence and they should be encouraged to keep the patient from becoming too dependent during this period. The family should be told of the community agencies which can provide for recreational, financial, or other needs during this time.

INTERCHANGE OF MEDICAL AND NURSING INFORMATION

The nurse who has had little or limited experience in caring for patients with glaucoma will need careful guidance from her supervisor. Frequent conferences with the physician in charge of the patient will help the nurse keep informed as to the medical plans for the patient, any change in plans, and at the same time will give her an opportunity to pass along to the physician her own observations of the patient's progress and acceptance of medical care, and of new problems or complications as they arise. If it is not possible to have conferences with the physician then progress reports should be sent to the physician at regular intervals, giving information as to the general home situation, specific instructions which the nurse has given the patient, presence of new complaints,

minor illnesses such as colds, gastro-intestinal upsets, and the like, that may occur, and other information which the nurse feels is pertinent.

If the medical care which the patient is receiving is being given through a clinic, it is equally important to have this interchange of information between clinic medical personnel and the nurse visiting the home. This is especially true since the patient, if operated, will undoubtedly receive some insight into his illness from the nurse who gives bedside care, the clinic nurse, and the nurse who is doing home visiting. If close working relationships between all these medical personnel do not exist and each is not aware of the teaching being done by the other it may lead to general confusion for the patient, and a resistance to medical care may develop.

The correlation of the information which the public health nurse who observes the patient in his home supplies, and the information of the clinical personnel who have the clinical picture, may provide the answer to the now many unanswered questions about glaucoma.

Thus a specific plan for referral on discharge from hospital care, a summary of care and treatment given and a free exchange of information between all medical persons interested in the patient should be set up.

SUMMARY

Every glaucoma patient is an individual problem and deserves individual guidance and care. Public health nurses through their home visits and close contact with the older population groups in homes have excellent opportunities to stimulate and encourage medical care and observation, and thus bring about earlier diagnoses of persons suffering from glaucoma or of potential glaucoma cases. This will be a real contribution to the problem of glaucoma not only because it should bring about a decrease in the number of persons blind from glaucoma, but it will also provide an opportunity for more medical study and evaluation of the early factors which cause glaucoma.

Glaucoma patients present a real challenge to the nurse and at the same time provide an opportunity for giving real community service.

REFERENCES

Allen, Thomas. To prevent blindness from glaucoma. *Diseases Eye—Ear—Nose—Throat*, June 1942, v. 2, p. 186-188.

Halper, Philip J. Glaucoma. *Sight-Saving Review*, June 1936, v. 6, p. 83.

Kirby, Daniel. Glaucoma—a thief in the night. *Hygeia*, December 1940, v. 18, p. 1067-69; 1091; 1119.

Knighton, Willis S. Glaucoma and the prevention of blindness. *Sight-Saving Review*, Summer 1945, v. 15, p. 75-79.

Koch, Ferdinand L. P., and Virginia S. Boyce. Glaucoma clinic procedures. *Sight-Saving Review*, Summer 1945, v. 15, p. 92-105.

NAVAJOS LEARN BY DOING

TRESSA WALTERS, R.N.

NESTLED DEEP in the tall pines at the foot of the San Franciscan Mountains, fifteen miles from Flagstaff, Arizona, and one mile off Highway 66, a winding road leads to the Navajo Indian Village. The village was established in connection with the Navajo Ordnance Depot where the men were brought to work. The colorful regalia of the Indian adds much to this setting. The health problems here are a challenge to any teacher.

It was my privilege to teach a group of these Navajo women a course in Red Cross Home Nursing because the Post surgeon, Lieutenant Magladery, was most anxious that they learn how to improve the sanitary conditions of their homes, something about the symptoms of illness, the importance of coming to the hospital and clinic before it is too late, and some simple methods of home nursing and disease prevention.

Some of the questions which immediately came to me were: Can these people speak English? Can they read and write? Can I teach them to read a clinical thermometer? Do they have beds and sheets or do they sleep on sheep skins? All of these points were vital to me in planning.

The questions were all answered in the first lesson of the Red Cross Home Nursing Course, Unit I, "Care of the Sick." Women who could speak and understand English were chosen for the first group. It is hard to say whether the class or the instructor received the most satisfaction from the topics covered in this six-lesson course.

The Navajo women are very modest and shy, and at first it was difficult to get them to participate in class activities but they responded eagerly to friendliness and patience. The Navajo alphabet is very limited and it is difficult to translate into Navajo some of the English words.

The key words of Unit I are simple words for us to use, but it seemed that even more simple words had to be substituted. Of course, they learned by seeing the demonstrations and actually doing the procedures. They would grasp the new English words and say them over and over again as if these words were music to their ears, and beam with satisfaction when they had learned them. Some of the words were "friction," "flex," "rotary" and "moisten." They would frequently ask to have a new word written on the board and to have it pronounced many times. After each lesson, we reviewed the new English words which had been learned that day. They soon decided that turnabout was fair play, and that their instructor should learn some Navajo words. I asked them to teach me to say, "I like you." The answer was, "Too much one lesson." Upon hearing the guttural sounds, I decided it was too much for six lessons. However, I learned one word, "ya-te" meaning "hello" and greeted them in their own language.

The women soon decided they were being

Miss Walters is nursing field representative, American National Red Cross, Pacific Area, San Francisco, California.

One of the economic problems of the arid Southwest is the long and arduous trek for water. This young Navajo woman, Elta Blackgoat, walks a half mile every day to obtain water for her family.

kept too long in class, so after a shortened class period, time was spent discussing their tribal customs. They proudly educated their instructor on such customs as "the sweat bath." Their ways of doing things were compared with the methods learned in class. They often prolonged the sessions well over two hours. It was this friendly exchange that brought about a very close working relationship between instructor and class members, and a great deal of learning was accomplished.

The Navajos are naturally superstitious. This frequently came out while discussing the expression "M.D." I explained that this meant medical doctor and that he was the one to see when they were sick. They brought out that they were not ready to give up the "medicine man" altogether. The medicine man is paid in advance for "sings" for the ill; this would seem to be a profitable occupation on the reservation.

In planning their own diet to include some of all of the seven basic food groups, a volunteer was asked to tell what she was going to have for the evening meal. I knew what they all would have,—beans! Finally one woman volunteered, "yes, she was going to have beans." Together we helped her plan other foods she should include. Indian bread was mentioned and it was brought out here that it would be better for them if whole grain flour was used. They then asked the trader to get whole grain flour so they could buy it. Once, thoughtlessly I mentioned a poached egg. The immediate answer was "What's that?" "Tell us how." "Show us how."

The entire class learned to read the clinical thermometer and each bought one.

The teachers at the day school, together with the Flagstaff Red Cross Chapter, decided to give a party after the course was completed. Representatives from Indian Service, the Army, Arizona State College, and the local Red Cross were invited as guests. The women decided they would like to dress in their best native costumes for this celebration. They also decided they would like to dress their instructor in "squaw clothes" and take a picture. This really made me one of their tribe!

The party was a gala affair. The women "borrowed" their jewelry from "pawn" at the trader's for the event and it was returned

the next day. Each was dressed in a colorful velveteen blouse and skirt and highly decorated with turquoise and silver jewelry. Some costumes were trimmed with many dollars worth of silver coins.

They demonstrated many of the things they had learned in Unit I "Care of the Sick," for the benefit of the guests. All were pleased that my pupils had learned so many skills.

The class of women decided to form a committee from their own group to set up a permanent classroom at the village to be used to carry on more such courses. A room was offered by the day school teachers. The manager of the trading post furnished paint and one of the class member's husband painted it. The Indian Service and the Army post planned to furnish teaching equipment, the Flagstaff Red Cross Chapter the instructor.

This group had been promised a lesson on making a baby bed from three orange crates. As we worked that day on the schoolhouse porch, a non-English-speaking woman came by to watch. On her back she carried her infant, tightly strapped to a board. Here one of the helpers rattled off in Navajo the advantages of the "white" way of caring for the baby.

The women asked for classes for the Navajo-speaking groups also and offered to interpret. The educated Navajos have a deep sense of responsibility and a sincere desire to help their own people. It may be they feel instinctively that education will save their race. Whatever the reason for their acceptance, more ways of learning how to live in the world of the twentieth century should be taught them.

AN ALL-WORLD UNIFORM

IF ONE STUDIES AN unabridged life of Florence Nightingale, her comprehension of military matters and the affectionate honor in which she held religious sisterhoods, one gets an impression that the field of nursing was fathered by the army and mothered by the church. So we have a double heredity right to a special, distinctive uniform. In the fighting services each individual wears a foundation suit of a defined color and cut. Additional details of headgear, stripes, belts, bands, badges, and buttons are used to indicate rank and other differences. Such insignia also lend themselves to the furtherance of that personal human interest which helps towards understanding and cooperation. Conversely, a nun's vestments are marked by extreme conservatism and by great simplicity.

The consideration of an all-world uniform for nurses needs immediate attention. It would require time and thought and work by our international leaders, and would need to be buttressed by some kind of global agreement. Such prominent features of the two systems mentioned as fulfilling the needs of nurses could be incorporated into a costume, easily and quickly put on and off, adaptable to various emergencies and climates at home and abroad a basic dress of color and cut to denote any particular brand of service, also some distinguishing marks of rank, etc. Insignia convey facts, a story that is told; they are necessary. But for everyday use they should be few, and be calculated to arrest attention by their simplicity of design, to be noted and remembered. Confusion in the mind of the beholder is to be avoided or we defeat our own ends; for special occasions and for dress uniform, full regalia are in order. Taking a hint from the dress of nuns this universal uniform, once adopted, should not easily be abandoned nor subjected to fickle change. Then, come war, come pestilence, in that respect we shall be ready.

ANNE SIMSON-RATHBONE
In *The Canadian Nurse*, November 1948

EVALUATION: A CONSTRUCTIVE PROCESS

Although the student having her field experience is the subject of this discussion, the general ideas have meaning for any evaluative process

MARGARET SHETLAND, R.N.

IT IS THE PURPOSE of this paper to look critically at the methods of evaluation we are using to see how they can be made more constructive. We realize as do the students with whom we work that on the evaluation of their ability and progress during their practice experience rest major decisions that influence their acceptance and placement as public health nurses. In general, this responsibility is approached with humility and an honest attempt is made to produce a fair and true evaluation that the student can accept. Students are coming into the field today well prepared for the supervision and eager for the help we can give them. Our problem is that evaluation frequently is not part of a constructive process in which the student actively participates as she works toward her professional goals.

The most important purpose of evaluation is its contribution to professional growth. Evaluation becomes an instrument of professional growth only as the individual being evaluated participates in the process. The real value in the evaluation process lies in the growing ability of the individual to see some of her own needs as she progresses toward an ever extending professional goal. This type of evaluation is done by or with, not to or for people. Our responsibility then is one of helping her to identify some professional goals, to see where she is in her progress toward them, to understand what she needs to move forward, and finally, to extend her goals as she moves along. This sounds like a big order and it is, but it is an essential one if we hope to develop a body of responsible, self-directing, professional public health nurses.

What are some of the approaches and methods we can use in making evaluations an instrument of professional growth?

First, we need to consider the process of evaluation itself and our role in it. Actually, evaluation is one of the commonest of everyday activities. Self-evaluation ranges from looking to see if one's lipstick is smooth, to a searching self-analysis that is more likely to occur when we get into trouble or meet other obstacles. Evaluation of others has the same range,—from the lazy appraisal of a stranger on a street car to an analysis done with a psychiatrist. Evaluation of professional work is characterized by purpose, which we have identified, and standards which we will discuss.

Evaluation is always concerned with the individual and has different meanings to everyone. We need to be more realistic in what we expect of any individual in an evaluation situation. Is objectivity about oneself ever possible, particularly about the things that really count? As we try to help the new worker get a grasp on herself as a

Miss Shetland is associate director of the Bureau of Public Health Nursing, Michigan Department of Health, Lansing, Michigan.

professional person, we must avoid expecting too much of her, no matter how glibly "accepting" her overt responses may be. Subjectivity is reduced and growth potentialities increased if evaluation is oriented to the worker and the job rather than the individual. This concept, introduced by Virginia Robinson, is well known and space does not permit its development here.

EVALUATION IS always based on some kind of observation. It is essential that we consider the observations on which we base evaluation in public health nursing. Any such observation is always an interpretation, and whether we like it or not, no matter how objectively descriptive we try to be, it is a value judgment and reflects the philosophy, experience, personality of the person who makes it and at the time he makes it. No public health nursing situation is so simple that its description does not require selection from among the many things observed. This, and the way it is expressed, are interpretive of the observer as well as the person observed.

Furthermore, descriptions of behavior which are frequently and glibly considered objective because they describe "what actually happened," have little value unless we know whether they are typical and what they mean in terms of progress toward a goal. Therefore, participation becomes an essential in constructive evaluation. Unless we know what the nurse was trying to do and what her idea was in the way she was doing it, descriptions of situations become meaningless. Moreover, to make descriptive reports of this type valuable means that we must set up a conference situation in which the nurse's role is active rather than one which puts her on the defensive.

This raises a question as to the use of written reports. Certainly they have value and are indispensable tools. But are we too self-conscious about getting everything on paper? Aren't there some times when the written comment becomes a barrier to the professional growth which a less direct method might foster? We need to consider the basic purpose of evaluation and whether it would be better served by an "off the record" comment. Is it really essential to have it on paper and for what reasons? Will each comment really help the student or may it have a negative influence on her growth? Written reports of observations can be used constructively in evaluation when they become a tool used by observer and student as they analyze the situation together.

Evaluation as a professional growth directed activity assumes goals that are the student's, not ours. This process begins in the university when the student starts to think about field experience placement. Interpretation at this time of the place of field experience in the preparation of the public health nurse, what she can hope to gain from it and what will be expected of her is an important part of preparation for the experience and is significant in evaluation. If this is done well, the student is usually able to begin to formulate some goals for herself. Her work at the university has given her some idea of standards and she can begin to think of her own professional needs in terms of them. It is a mistake, however, to ask the usual student to formulate written objectives at this time. When this is done too early, the student is likely to produce something out of the curriculum guide, which is just about what we deserve. After the student gets to the field, sees the situation and the people, they see her and they work together a little, she and her field teacher can more easily formulate written goals that are attainable and are in terms of individual needs and the opportunities available. These goals or objectives should be subject to change as the student moves along in her experience. They should, however, provide the basis for evaluation of her progress. These are the tangibles which provide the student with a base for her own evaluation of her progress.

THE FIELD TEACHER is very often the key person in the evaluation process. It is she, more than anyone who interprets standards and it is she who, by her own attitudes toward evaluation makes it easier or harder for the student. She has excellent opportunities as she shares her work with the

student. The degree to which she can be analytical and critical yet comfortable as she discusses her own work with the student, helps the student or hinders her. The field teacher's acceptance of evaluation as an everyday vital part of everyone's work helps the student think about it with less fear. If the field teacher is at ease and not too self-conscious about her work it is easier for the student to be. And, blessed is the student whose field teacher sees the many satisfactions in her daily work and helps the student to see them, too. Not only the tangible accomplishments, but some of the little things,—the delight of a child in seeing her mother's nurse in school, the pleasure of the young mother in displaying her baby to the visitors, all the little things that make our work good and satisfying.

Also fortunate is the student who has field experience in an agency where there is real team work. Here evaluation is in proper perspective. Everyone is working toward doing a better job and everyone questions program, policy, and technics in a free give and take to improve the job done. Evaluation here is part of a democratic dynamic process in which everyone shares and where the student gets help in establishing goals and standards for herself.

The family study conference is another opportunity which the student can use to develop professional standards and get some help in moving toward them. This method has more value for the student when it is a usual part of the staff activities rather than a special student activity. The value to the student is increased when she can see the way in which staff members in various stages of growth and experience make their contributions to the group and learn from each other.

There are many specific methods we can use to make evaluation a constructive experience. The methods themselves are probably less important than our attitudes toward them and the way that we use them. In order to be effective, we must—

1. Recognize that we can help the student use evaluation constructively. We cannot make it constructive.

2. Appraise the methods we use in terms of the purposes we hope to achieve. At present, we are using some methods that hamper more than help growth.

3. Realize that each student grows at her own rate and in her own way. Evaluation must be individualized. If we decide that the student has potentialities for public health nursing, our job is to help her grow toward professional maturity in the best way she can, which will be different from others. We can hinder her by expecting too much, too little, or the wrong things, or at the wrong time. But we can be of help to her if we put her in situations which require all of her growing skill, and help her see how she is gaining skill in meeting situations of increasing difficulty.

FRONTAL LOBOTOMY

IRVING J. SANDS, M.D.

FRONTAL LOBOTOMY, pre-frontal lobotomy, psychosurgery, and frontal leucotomy are different designations of a new method for the treatment of certain chronic and heretofore incurable mentally sick people. The method was first described some 10 years ago by Dr. Moniz. It was introduced into this country by Doctors Freeman and Watts of Washington, D. C. In the past 2 years it has been recommended and used by a large number of psychiatrists and neurosurgeons.

In order to understand more fully the significance of the method, the reader must have the following facts in mind. There are a large number of chronic psychotic patients who resist all forms of treatment, even insulin shock therapy, or convulsive therapy by metrazol and electricity. In the process of evolution of the brain, the frontal lobes have developed to comprise approximately one third of the entire cerebrum of the human brain. The frontal lobes concern themselves with the highest functions of human activities, such as feeling, thinking, reasoning, and planning. In one sense it is the lobes that differentiate human beings from animals. These frontal lobes are connected with the rest of the nervous system, and have a direct connection with the thalamus, that part of the brain which primarily deals with sensations. The stimuli received by the frontal lobes from the rest of the nervous system, are integrated and correlated in such a manner as to enable the individual to function on a proper level and help him to adapt himself to his environment. It has been found that when the connections of the frontal lobes with the thalamus are severed, the human being is no longer able to perceive pain as is ordinarily done in a normal healthy state. Moreover, the process of reasoning is not seriously interfered with after such an operation. When these connections are interrupted, pain is no longer perceived as such, since the sting of it has been removed. Furthermore, it has been noted that anxiety states and various tension states are markedly diminished. For this reason, Dr. Moniz introduced a method which disrupts the connection between the process of thinking and the process of feeling. The object of his method is to cut the fibres leading from the thalamus to the frontal lobes. Burr holes are made in the frontal area of the skull, and a dull instrument is introduced in such a manner as to cut these fibres. Several modifications of this method have been introduced, but these are merely of technical and neurosurgical interest. The point to remember is the purpose of such a method, namely, the severance of the nerve fibres connecting the frontal lobe with the thalamus. The operation is performed with the usual surgical technics employed in neurosurgery.

Post-operatively the patients may show various clinical phenomena, such as confusion, stupor, and memory impairment, and, quite commonly, incontinence of the sphincters of the bladder and of the rectum. These may last for a few weeks; hence, it is very important that the patients receive expert nursing care and treatment for at least a month after the operation.

In approximately 5 to 7 percent of operations, fatalities have occurred as a result of

Dr. Sands is assistant clinical professor of neurology, Columbia University School of Medicine, and author of "Neuropsychiatry for Nurses" *published last year.*

hemorrhage. Moreover, in about 5 percent, convulsions have followed the operations. The method, therefore, has definite drawbacks.

In approximately one third of the patients treated in this manner, there has been marked improvement in their condition. Quite a reasonably good number of the patients have returned to their homes, and have even resumed some gainful occupation. In another third of such cases, the results have been reasonably good, and in the remaining third no change in the behavior has occurred. In an insignificant number of patients their condition has become worse.

Despite the fact that this method is only a recent acquisition in the treatment of chronic psychotics, it has produced most desirable results in many cases. For example, a 45-year-old housewife, the mother of three children, had been confined to a psychiatric hospital for a decade. She would tear her clothing, wet and soil herself, and did not respond to insulin, metrazol, and electric shock therapy. She was subjected to a frontal lobotomy. Six weeks after the operation, she returned to her home. For the past year she has been with her family, is able to do a little housework, and has been able to assume a position in her family circle. Another young woman of 35 was in a psychiatric hospital for 5 years suffering from schizophrenia. She was disturbed and resisted all form of care. Insulin, metrazol, and electric shock therapy failed to make any impression on her illness. A frontal lobotomy was performed, she improved and was discharged from the hospital. Three months later she was doing some clerical work in a merchandising office. These cases are illustrative of how effective this form of treatment can be in a certain number of patients.

In the past year or two frontal lobotomy has been used for the purpose of relieving intractable pain caused by incurable disease, such as that due to metastatic tumor lesions. There are a certain number of such patients in whom all efforts to relieve the pain have either been unsuccessful, or in whom certain other methods of treatment, such as cutting the sensory pathway for pain in the spinal cord, may not be feasible. Thus a 42-year-old man was admitted to the hospital for intractable pain in his chest and in his upper extremities. A lobe of the lung has been removed and x-ray treatment was given to the spinal column. Upon investigation, it was disclosed that he was suffering from a carcinoma of the lungs which metastasized into the lower cervical and upper thoracic regions of the spinal column. It was recognized that this man's condition was of such a character that he had but a few months of life left. It was planned to cut the sensory tract in the spinal cord, but such a procedure might be followed by paralysis to one half of the body, and possibly disturbance of the control of the sphincters of the bladder and of the rectum. A pre-frontal lobotomy was therefore performed. The relief from pain was immediate. When questioned about it he said that he did feel pain but it no longer "hurt" him. He was able to sleep and was no longer requiring opiates to control his pain.

It is imperative that every case should be carefully studied, re-examined, and analyzed before being subjected to this method of treatment. Every patient should first be given the benefit of other forms of treatment, such as the various types of shock therapies, and intensive psychotherapy, before being subjected to this operative procedure. It must be remembered that frontal lobotomy does carry with it certain serious complications, such as cerebral hemorrhage and post-operative convulsions. Best results will be obtained by careful selection of patients for lobotomy.

SUMMARY

Frontal lobotomy is a method of treating certain types of psychotics and some patients suffering from intractable pain caused by incurable disease.

The method consists of cutting the nerve fibres that connect the frontal lobes and the thalamus.

Only suitable patients should be submitted for such treatment.

The progressive nurse will do well to acquaint herself with the principles involved in this new form of treatment.

TRENDS IN MEDICINE AND PUBLIC HEALTH

PICK A SEDENTARY HOBBY

The fact that of all the people who live to be 65 years old, three-fifths of the men and over two-thirds of the women will live to see their 75th birthday, points to the need to make these years healthy and happy.

Man devotes the first 25 years of his life to preparation for maturity, to learning a trade, an occupation or a profession. When this preparation has been achieved, his daily round demands increasing application, activity and responsibility, and the stress and strain in executing the daily program are increased. Man gives little consideration to preparing for the postprime years of life when the inevitable biologic laws exact modifications in his mode of living and working. Thus Dr. Fredrick A. Willius (*Proceedings* of the Staff Meetings of the Mayo Clinic, September 1, 1948) points out the need for a constructive approach to middle age and beyond for each individual and for the realization that through the "normal metamorphosis of the aging process or through the unanticipated occurrence of a physical handicap his accustomed strenuous or semistrenuous hobbies no longer can be enjoyed." Rather than becoming a hapless, depressed and often frantic personality, man should adopt interesting, sedentary hobbies, relatively early in life, avers Dr. Willius. He mentions the case of the American grandmother who adopted oil-painting as a hobby after the age of 60, who now enjoys the admiration and respect of artists for her superb work. Everyone cannot become an artist but there are countless comparable hobbies available to those who seek them.

Concludes Dr. Willius: "It is only when this type of philosophy is accepted and made to work that the later years of life through natural sequence, or the earlier years of life through physical misfortune, can be made interesting and pleasurable."

GERMICIDAL LIGHT IN CLASSROOMS

"Light within buildings, whether natural or artificial, is of esthetic import of course, but its more important functions are to facilitate seeing, to give a psychological lift, and to exterminate germs." So writes Isadore Rosenfield, architect and hospital consultant, in *American School and University—1948-49 Edition,* about architectural improvements in school and hospital structures which will help raise the standards of health.

Experiments on the germicidal effectiveness of indoor lighting have shown, by testing the effects of sunlight and daylight passed through the glass of a window and the glass covers of Petri plates on streptococci and pneumococci, that "diffuse daylight is a patent lethal agent." It may thus be concluded that the concentration of infection-causing organisms is reduced by natural daylight and sunlight, and that there is a need for planning a maximum of window space in new hospitals, schools, and homes.

The first step is proper spacing and orientation in building. The principles of orientation differ in the different climates. In the tropics, the preferable orientation is away from the sun and in the direction of the prevailing breezes. In the temperate zones buildings must be designed for two distinct climates,—tropic in summer and sub-arctic in winter.

Concerning big windows and glass walls—

how are we to control strong sunlight when it is not wanted? Shades can be pulled, but the better way is to introduce a shelf outside, over the window, designed with regard for the solstice in relation to height and depth of the room. The shelf should permit sunlight to penetrate the room in the months it is wanted, and to cut it off when it is not wanted. The problems of all exposures cannot be solved with one device. Better results are obtainable if each exposure is analyzed separately, and treated accordingly.

Actinic glass transmits about 60 percent of the ultra-violet spectrum. It is preferable to ordinary glass from the germicidal point of view. Little is known about it, however, as a health-contributing agent.

Ultra-violet irradiation is germicidal. However, certain factors nullify to a certain extent its effectiveness when installed in classrooms (1) pathogens released by one can be inhaled by another person before irradiation takes effect (2) even if fully effective in the classroom, it is nullified by contacts in the bus, home, movies, et cetera (3) ultra-violet irradiation can't reach germ laden dust on the floor.

Natural light or daylight has illuminating and germicidal properties in one, but not artificial light sources. Ordinary incandescent or fluorescent sources are not materially germicidal. Only ultra-violet sources are. To obtain an artificial germicidal agency in a classroom it is necessary to install two sets of fixtures,—one for light and the other for germicidal purposes. This is not practical. Also the application of ultra-violet is fraught with dangers (1) undue exposure of the eye to ultra-violet rays causes conjunctivitis (2) the higher the intensity of the source, the more reflection there is from the ceiling—and experience shows that even reflections can be injurious to the eye or skin (3) while not every finished surface has a high enough reflection factor to be a serious problem in design, some types of paint are better than others. Ultra-violet rays will brown many paint vehicles, drapes and wallpapers.

It may be said, therefore, that natural window light and artificial ultra-violet are germicidal, but their specific application in schools and related environments needs further study. It is necessary to study their relation to each other and their possible substitutes, such as natural and artificial ventilation as well as other methods such as chemical air sprays, floor oiling, and the like.

ACCIDENT-PRONE CHILDREN ARE POPULAR

The number of injuries children get is a measure of their friendships, Dr. Elizabeth M. Fuller, associate professor of child welfare, University of Minnesota, has found in a study of "accident-prone" children. These children were "discovered" rather incidentally during a first aid survey made by Dr. Fuller and her staff. They found that children most often hurt had the same group of personality traits.

The accident-prone children observed were brighter, more alert, more active, and more popular, but they were not always perfect. They were often rude, daredevilish, impulsive, impatient, and sometimes obstinate. They were usually well developed physically, and possessed better motor coordination. This advantage helps them to avoid even more injuries than they do get. The physically able child gets himself into many situations conducive to accidents.

Is there such a thing as real accident proneness in children, or is it that the child who gets around more meets more opportunities for injury? Dr. Fuller believes there is accident-proneness, and she is conducting a definite long-time study of the subject. It is her hope to find an active child who doesn't have accidents. This would be her first evidence that activity alone is not the cause of frequent injuries; that there is accident-proneness. Dr. Fuller's findings so far point in that direction. When her work is more fully developed, attempts can be made to train these children to avoid accidents.

X-RAYING HALF A MILLION

During the first half of 1948, a mass chest x-ray survey was conducted in Washington

by the D.C. Health Department, USPHS, and D.C. Tuberculosis Association. The health department assumed over-all direction of the survey; the Tuberculosis Association took responsibility for the program of health education, community organization, and publicity; and the USPHS contributed the requisite equipment as well as the professional, technical and clerical personnel. This project was reported in NTA *Bulletin*, December 1948.

The survey was preceded by a three-month planning period in which the representatives of the three agencies formed the survey operating committee to assist in coordinating the survey through general planning, organization, policy making, and budget approval. Later the operating committee formed a series of planning committees to enlist all community leaders and resources in the drive to x-ray 100 percent of the adult population—promotional committee, medical technical committee, scheduling committee, community organization, government employees, and public information committees.

The medical technical committee was composed of doctors, nurses, and social workers. Subcommittees were formed to assist in the diagnosis, treatment and follow-up of the tuberculosis cases found during the survey and to render necessary nursing and social services.

The subcommittee on nursing activities centered around a volunteer group of nurses affiliated with the local graduate nurses' association. This group offered its services in follow-up of those persons who failed to respond to the request originating from survey headquarters for their return for a 14″ x 17″ film when need for this was indicated in the smaller 70 mm. films. Only 3.5 percent of the 18,704 persons requested to return failed to comply and the majority of these persons did return when approached by members of this subcommittee.

Though actual x-raying has been completed and 503,414 films taken and read, the work of the sponsoring agencies is far from finished. This mass screening showed that of the total number of persons examined, 1.5 percent were found to have possible tuberculosis. Planning and caring for these persons will call for a continued program of action by the survey committees and the community during the 2-year follow-up period. Within this time the program must be evaluated, ways and means found to provide hospital facilities for the ill. In many cases financial aid must be secured for the patients.

THERAPEUTIC PNEUMOTHORAX TODAY

The less frequent use of pneumothorax in the treatment of pulmonary tuberculosis is pointed out in an editorial by J. N. Hayes in the October 1948 *American Review of Tuberculosis*. It was the principal weapon used in the treatment of pulmonary tuberculosis in the 1920's. Because of the frequency of empyema, inexpandible lung and reactivation of the disease following reexpansion of the collapsed lung, as indicated by statistics in general, its use today is in danger of being neglected.

Pneumothorax is now regarded as a tentative procedure and its use is dependent upon the type of lesion, its location in the lung, and the success of other collapse measures which are less hazardous to the patient. Phrenic nerve interruption, pnemoperitum and thoracoplasty are used more widely than previously. Chemotherapy has also had its effect on the choice of pneumothorax in the treatment of pulmonary tuberculosis. Pneumothorax is a much safer procedure than earlier studies indicate, however. This is probably because of better choice of patients. A period of bed-rest sufficiently prolonged to permit a subsidence of the most active inflammation has become a routine procedure. Early pneumonolysis and the early cessation of pneumothorax if effective collapse does not seem possible, have resulted in a more favorable outcome of the disease. Primary thoracoplasty has become advisable in many instances, without prior attempt at pneumothorax. A lobectomy, or a short term Monaldi operation for tension cavities, followed by thoracoplasty, have become a choice of treatment. Formerly pneumothorax was the principal treatment for all types of lesions.

DIHYDROSTREPTOMYCIN FOR TUBERCULOSIS

Dihydrostreptomycin is a compound which is derived from streptomycin and it has the same range of anti-microbial activity. It has been used on experimental animals and is now being administered to patients in selected research centers. Reports of research in the use of dihydrostreptomycin are to be found in the November 1948 *American Review of Tuberculosis.*

Sufficient evidence has been accumulated to indicate that dihydrostreptomycin is an effective drug for the treatment of some types of tuberculosis. Its activity is similar to that of streptomycin however it seems to be less toxic. It is well tolerated by patients who are markedly allergic to streptomycin.

Administered over long periods dihydrostreptomycin causes reactions similar to those caused by streptomycin. However these reactions such as vestibular damage appear less uniformly with 5.0 gms of dihydrostreptomycin daily than with 3.0 gms of streptomycin daily and when administered for a three months period produce little or no toxic symptoms.

It was found in one series of 12 patients that resistant strains of tubercle bacilli have emerged during treatment with dihydrostreptomycin in the same way as with streptomycin.

An unfavorable attribute of dihydrostreptomycin is the irritation of the tissues at the site of injection. The series of patients reported was small and further research will have to be done before the possible toxic potentialities of dihydrostreptomycin will be revealed.

In summary it seems to have proved to be useful in the treatment of patients unable to tolerate streptomycin because of hypersensitivity. Because of its lower neurotoxicity it can be given over a longer period and in larger doses than streptomycin.

RESEARCH ON CANNED FOODS

A six-year, nationwide program of scientific research into the nutrient values of canned foods was described recently as "providing more knowledge about canned nutritive values than had become known since the discovery of vitamins at the turn of the century."

Dr. E. J. Cameron, research director of the National Canners Association, says, "the new knowledge unearthed by the research program enables homemakers, military officials, and institutional dietitians for the first time in history to use canned foods on a day-to-day basis with complete data on the vitamins, minerals and calories to be found in more than 40 different canned foods that are consumed in large quantities."

Findings are, in brief:

1. High ratios of vitamins, minerals, and calories are retained in canned foods packed for standard commercial use.

2. Normal dietary requirements for nutritional factors supplied by cooked foods of various types may be met through selective use of canned foods with special characteristics in terms of caloric, vitamin and mineral content.

3. On-the-spot scientific processing of fresh products, as practiced in the commercial canneries, plus application of standardized quality control methods, retains relatively large amounts of essential nutrients, in contrast with many types of home cooking which disperse nutritive elements or destroy essential elements by over-heating.

4. Protection of heat-sensitive nutritive elements, notably thiamin and vitamin C, may be fostered indefinitely in canned foods by avoidance of high-temperature storage conditions.

5. Notable improvements in food-research methods have been effected, through development of standardized technics to compensate for seasonal and geographic variables, and eliminate non-uniformity of research methods.

6. Home economists now have available scientifically proven food composition tables for use in selecting canned foods with differing characteristics.

7. Detailed information is now available to guide homemakers on the most efficient and economical use of canned foods, through avoidance of home preparation methods which waste essential nutrients. An example is that a large percentage of the nutrient value of

canned foods has been proved to be contained in the liquid portion, hence the need for housewives to reduce the liquid portion of vegetable foods to one fourth the original volume and serve the concentrated liquid along with the solid portion.

Important phases of the research are still under way. One has to do with canned food protein in terms of amino acids.

PREPARATION FOR HEALTH TEACHING

In the report of the *National Conference on Undergraduate Professional Preparation in Physical Education, Health Education and Recreation*, public health nurses will be especially interested in the sections on "Professional preparation in health education" and "Functions of health teachers in the health service program."

The health service program in schools is said to involve the cooperation of many individuals and groups. Specifically, the health teacher assists the school administrator and school medical adviser in planning a program which includes (1) the health appraisal of students including periodic and referral medical examinations (2) procedures for health guidance and follow-up (3) procedures for care of emergency illness and accident (4) procedures for the control of communicable diseases (5) provision for adjustment of the school program to the needs of exceptional students (6) provision for the health of the teacher.

The objectives, values, and limitations of the school health service program are said to be often misunderstood by students, teachers, parents, and the public. The health teacher helps to interpret the service and as a result of acquired understanding school and community are then welded into a force to support increased services for the health of the student and his family.

In preparation for his job the health teacher needs to gain insight into the three major functions of his future job (1) giving individual health guidance and group instruction in matters of personal and community health (2) assuming responsibility, with others, for emphasizing the health implications of the child's total environment and (3) aiding in promoting an adequate health service program which makes best use of all community resources. The undergraduate curriculum directed to these ends will require general education as well as special courses, supplemented by practical experience.

Copies of the report are $1, available from the Athletic Institute, 209 S. State Street, Chicago 4, Illinois.

MORTALITY FROM RHEUMATIC FEVER

Rheumatic fever, a serious health hazard of childhood, shows up as a greater danger for Negro children than for white children, Dr. George Wolff reports in, "Childhood Mortality from Rheumatic Fever and Heart Diseases," issued by the Children's Bureau.

Throughout the United States, wherever the death rates are based on large enough population numbers, the nonwhite children show a higher mortality for rheumatic heart diseases than the white children. Among nonwhite children, 5 through 19 years, there are 16.6 deaths reported per 100,000 population; among white children there are 11.1 deaths. For some states with large Negro populations, the death rate among Negro children is considerably greater, sometimes more than double the rate for white children. The consistently higher mortality rates among nonwhite children in all probability are related to the less favorable socio-economic conditions in which many of them live.

In addition to racial differences in the death rates from rheumatic fever, there are also differences in age groups and between the sexes. The death rate from the disease is higher for older children. In the period between 15 and 19 years a significant sex difference is found in both racial groups. In these ages the white boys have higher death rates than the white girls. On the other hand, nonwhite girls exhibit markedly higher death rates than the nonwhite boys.

In general, the mortality rate is highest in the Middle Atlantic States and lowest in the Pacific Coast States, with the rate tending to decrease across the country from Northeast to Southwest.

NEW BOOKS
AND OTHER PUBLICATIONS

THE NATION'S HEALTH

A Report to the President by Oscar R. Ewing. Washington, D.C., U. S. Government Printing Office, 1948. 186 p. $1.00.

This report is essential reading for all health workers. Published in September, it has created explosive reaction all over the country. Nine goals are presented to improve the nation's health and plans offered to achieve the goals. The plans offered to reach eight of the goals are essentially those presented by the National Health Assembly. Mr. Ewing presents his own plan to achieve goal 3 in Chapter 4. Some of the members of the Medical Care Section of the National Health Assembly endorsed it and some did not.

To this reviewer the climax is reached in Chapter 4. Mr. Ewing states that full access to medical services by all the people can only be secured by a governmental health insurance program. He outlines a program of action and states the reason for his proposals. The proposed program is a welcome ally to proponents of, and a challenge to opponents of, compulsory governmental health insurance.

—M. FRANCES FRAZIER, *Instructor of Public Health Nursing, Harvard University School of Public Health, Boston, Massachusetts.*

SHAME OF THE STATES

By Albert Deutsch. New York, Harcourt, Brace & Company, 1948. 188 p. $3.00.

This is a report of a survey with actual photographs of a representative number of state hospitals for the mentally ill. The pictures by camera and pen are not happy ones. The lack of well prepared staff and facilities is startling. Not one of the hospitals attains the minimum standards as set up by the American Psychiatric Association, many fall far below. I cannot resist as a Brooklynite pointing out that the Brooklyn State Hospital is one of the best where more therapy and more care for the patient is emphasized. Mr. Deutsch urges that future state hospitals be part of a medical plan near the center of population instead of isolated. They need to be affiliated with teaching hospitals and medical schools. He cites the spectacular reform in veterans hospitals by General Bradley as a pattern for new and efficient possibilities in state hospitals. In the final analysis he puts it squarely up to us as he places his emphasis on team work between the doctor, public health nurse, and the social worker and us—the public. Better care of the mentally ill patient is *our* responsibility.

—MRS. JEAN A. CURRAN, *160 Henry Street, Brooklyn, N. Y.*

THE PLAGUE AND I

By Betty MacDonald. Philadelphia, J. B. Lippincott, 1948. 254 p. $2.75.

This book relates the author's experiences as a patient in a tuberculosis sanatorium. It includes a good description of the patient's feelings on being told she has tuberculosis and something of the adjustment necessary to return to a normal way of living.

The hospital period took place some time ago when the treatment of the patient did not include all the care and understanding that is considered essential at the present time. There is excellent characterization of some of the patients. The author is able to find considerable humor in the hospital situation but for the most part is very critical of the routines of the hospital and in the attitudes

of the personnel. She infers that the treatment of the tuberculous is dependent on the discipline imposed upon the patient and not on the patient's understanding of the reason for the treatment. It is difficult to believe that such a lack of understanding could exist.

The reviewer would like to mention the difference in attitudes presented in this book and in the one, "Taking the Cure," written by Doctor Robert Louell.

It would seem this book might dishearten people about to enter the sanatorium as patients and they would need considerable encouragement to be convinced that a better philosophy of the needs of people exists at the present time.

—MILDRED SPELLMAN, *Tuberculosis Nursing Consultant, Michigan Department of Health, Lansing, Michigan.*

VOLUNTARY MEDICAL CARE INSURANCE IN THE UNITED STATES

By Franz Goldman. New York, Columbia University Press, 1948. 228 p. $3.00.

First started in the United States in the mid-nineteenth century, as part of the program of mutual benefit associations and fraternal beneficiary societies, voluntary medical care insurance has expanded rapidly during the past 20 years. Dr. Goldmann describes the development of the various types of voluntary hospital and medical care plans; discusses the principles of medical care insurance and the characteristics, functions, administration, and operation of such insurance plans; analyzes, evaluates and illustrates the policies and practices of various cost indemnity plans, nonprofit hospital service, physicians' service, and combined hospital and service plans, and group practice plans, and outlines limitations and potentialities.

Of special interest is the discussion of education needed for those concerned in insurance plans,—recipients of care, professional people, hospitals, administrators. Nurses should note that plans usually provide for general nursing services in hospitals, clinics, industrial plants, but only infrequently include special duty nursing in hospital or home, or visiting nurse service in the home.

This book is a comprehensive quick reference on voluntary medical care insurance.

—MARY T. COLLINS, R.N., *Secretary of the ANA and NOPHN Joint Committee on Nursing in Prepayment Health Plans.*

GIVE THEM A CHANCE TO TALK

By Bernice R. Rutherford. Minneapolis, Burgess Publishing Company, 1948. 116 p. $2.75.

This handbook is designed primarily as an aid to speech therapists working with cerebral palsied children. Based on her invaluable experience at Dowling School, the author has compiled a wealth of specific information which should fill a long felt need in this rapidly growing field of interest. Throughout the book she repeatedly stresses recognition of the individuality of the patient in relation to his needs and special training. Also included is pertinent material regarding the adults in the child's environment, and their responsibility in helping him gain greater personal, physical, and social independence.

The discussion of allied problems is of necessity brief but greater emphasis could have been given the types of medical and retraining problems (e.g. use of hearing aids and lip reading instructions) associated with hearing loss.

While this text is fairly technical for use by parents, it should offer help to speech therapists and be a valuable reference to other allied specialists working in a coordinated cerebral palsy program.

—HEDWIG B. TRAUBA, R.N., *Supervisor, Nursing Services and* JEANNETTE FRASIER, S.P. *Supervisor, Speech and Hearing Services, University of Illinois.*

PSYCHOLOGICAL ORIGIN AND TREATMENT OF ENURESIS

By Stevenson Smith. Seattle, The University of Washington Press, 1948. 70 p. $1.75.

The author is professor of psychology at the University of Washington where he is also director of the Institute of Child Development. The book is addressed to both laymen and professional workers. Its tone of good humor and practical common sense as well as the very specific suggestions for combating

bed-wetting, will give it a wide appeal. Professor Smith emphasizes the importance of the parents' role, and good family relationships as the chief factors for success with this difficult problem. The chapter, Preparing the Child for Learning, deserves to stand by itself as a small gem on the subject of discipline. But when all is said and done the author still pins his hope for a cure, to "reconditioning" and the training process. He brushes aside as "unscientific" the conclusions of equally careful clinicians that stubborn cases of enuresis are associated with unconscious conflicts of a sexual nature and that these must be resolved before the child as well as the symptom itself can be considered cured. Professor Smith's procedures may, in the hands of the right adults be helpful in some cases. In those same hands they are unlikely to do harm. But we suspect that the problem of enuresis is more complex than this author finds it and that the deeper meanings of this disturbance have eluded him.

—ANNA W. M. WOLF, *Child Study Association of America, 221 W. 57 Street, New York, N. Y.*

SUCCESSFUL MARRIAGE

Edited by Morris Fishbein and Ernest W. Burgess. New York, Doubleday and Company, 1948. 515 p. $6.00.

Characteristic of our age is the consistent attempt of socially responsible men to combat superstitions with fact, and to replace hopeless muddling with expert analysis and systematic, constructive effort. This book represents such an attempt by the combined effort of 38 distinguished authors.

Each has devoted himself to one phase of the general subject of courtship, marriage and family living, so that the range is impressive. Materials on mixed marriages, however, are absent, as well as the more significant conclusions of the now famous Kinsey Report. The focus is on personal problems rather than on larger issues of population and the community.

The book is readable and gratifyingly frank. Moralistic bias is largely avoided in favor of objective information, and the multitude of problems is handled constructively. A number of chapters include selected bibliographies, which may encourage further study of particular subjects.

Read carefully and judiciously, this book can go far in helping many people build happier marriages.

—MILTON C. ALBRECHT, *Associate Professor of Anthropology and Sociology, University of Buffalo, N. Y.*

HANDBOOK OF ORTHOPAEDIC SURGERY

By Alfred Rives Shands, Jr. 3rd edition. St. Louis, C. V. Mosby, 1948. 574 p. $6.00.

Dr. Shands is to be congratulated on the clear, concise and simple manner in which he has presented the many problems arising in orthopedic surgery. Equal importance is given to the prevention and correction of deformities. Those of the nursing and allied professions whose work lies in this field will find it an extremely interesting and informative book and one which at all times may be used for ready reference. The importance of a thorough understanding of the principles of good body mechanics is stressed throughout the book. A comprehensive bibliography is provided for further investigation on this subject.

—ELISE DUNLOP, *Supervisor, Nassau County Department of Health, Mineola, L. I.*

LETTERS TO JANE

By Gladys Denny Schultz. Philadelphia, J. B. Lippincott, 1948. 224 p. $2.75.

This book should prove valuable to mothers of late teen age boys and girls. The questions presented are those of the upper high school and early college group throughout the country. Mothers of children of this age will do well to read this book for it brings them face to face with the problems that confront their children. It can be given to the young people themselves and if the parents have read it—the book can serve as an opening wedge for a frank discussion of sex.

Mrs. Schultz's style of writing is so intimate that she holds the reader's interest. Almost any teen ager (or parent) can think of people like those portrayed in the book. Mrs. Schultz quite cleverly helps young people

make their own decisions based on what they believe fundamentally to be right and of lasting value.

One gets the feeling that the author is mature enough to have had a wide experience and yet young enough in spirit to understand the problems of to-day.

—MARION PETTIFORD HERNANDEZ, R.N., *District Secretary, Planned Parenthood Committee of Mothers' Health Center, New York.*

CHILD CARE

PIERRE THE PELICAN SERIES. A series of 12 illustrated pamphlets written for parents in simple language, emphasizing mental health for all the family. Lloyd W. Rowland, Director, Louisiana Society for Mental Health, 829 Hibernia Building, New Orleans 12, Louisiana. $1.00.

HELPING CHILDREN IN TROUBLE. Pub. 320. Federal Security Agency, U. S. Children's Bureau, Washington, D. C. 1947. 17 p.

GENERAL

HIGHLIGHTS OF THE NATIONAL CONFERENCE ON FAMILY LIFE. Washington, D. C., May 1948. Published by the National Conference on Family Life, 10 East 40 Street, New York 16, N. Y. 23 p. 15c

HEALTH PROGRESS 1936 TO 1945: A supplement to Twenty-Five Years of Health Progress by Louis I. Dublin. 147 p. Metropolitan Life Insurance Company, N. Y. 1948. Distributed to a selected list of libraries and specialists in public health and allied fields.

IMMIGRATION PROBLEM. Clarence A. Peters. New York, H. W. Wilson Company, 1948. 254 p. $1.25.

MAGIC IN A BOTTLE. Milton Silverman. 2nd edition New York, Macmillan Company, 1948. 386 p. $3.50.

SANITATION FOR FOOD HANDLERS AND SELLERS. Berl Benmeyr. Los Angeles, The American Institute of Sanitary Science, 1948. 126 p. $4.95.

BUYING YOUR OWN LIFE INSURANCE. By Maxwell S. Stewart. 32 p. No. 134. 1948. 20c. Public Affairs Committee, Inc., 22 East 38th Street, New York

"TO SECURE THESE RIGHTS" IN YOUR COMMUNITY. American Council on Race Relations, 4901 Ellis Avenue, Chicago 15, Illinois. June 1948, 59 p. 50c per copy.

HEALTH EDUCATION

PERSONAL AND COMMUNITY HEALTH. C. E. Turner 8th edition. St. Louis, C. V. Mosby Company, 1948. 565 p. $4.00.

GOOD NEWS ABOUT DIABETES. By Herbert Yahraes. Public Affairs Pamphlet No. 138. Public Affairs Committee, Inc., 22 E. 38 Street, New York 16, N. Y. 1948. 32 p. 20c.

NURSING EDUCATION

BOOKS SUGGESTED FOR LIBRARIES IN SCHOOLS OF NURSING. Compiled by The Committee on the Nursing School Library. National League of Nursing Education, 1790 Broadway, New York 19, N. Y. 1948. 197 p. $2.00.

INTRODUCTION TO CHEMISTRY. Bertha S. Dodge. St. Louis, C. V. Mosby Company, 1948. 312 p. $3.50.

NUTRITION

A LABORATORY MANUAL IN COOKERY. By Doris Johnson. New York, G. P. Putnam's Sons, 1948. 151 p. $2.50.

POLIOMYELITIS

WHEN YOU HAVE POLIO. 21 p. 1948. Prepared by the National Foundation for Infantile Paralysis, 120 Broadway, N.Y.

A booklet of questions and answers, many of which will assist the public health nurse in health supervision and guidance of convalescent poliomyelitis patients and their families.

RHEUMATIC FEVER

PROGRESS—NEW HAVEN RHEUMATIC FEVER AND CARDIAC PROGRAM. *Health.* September 1948, p. 2-3. New Haven Department of Health, New Haven, Connecticut.

SAFETY

BUTCH LEARNED THE HARD WAY. Bulletin No. 95. U. S. Department of Labor, Bureau of Labor Standards, Washington 25, D.C. 1948. 16 p. Limited supply free.

TUBERCULOSIS

CHEST X-RAY SERVICE IN ACTION. National Tuberculosis Association, 1790 Broadway, New York 19, N. Y. 1948. 111 p. $1.00.

A symposium of chest x-ray services compiled to meet demands for information from those interested in comprehensive tuberculosis control programs.

SATISFYING WORK AND A GOOD LIVING. Prepared by The Connecticut State Tuberculosis Commission, 119 Ann Street, Hartford, Connecticut. 1948. Available for general distribution without charge.

LIFE, DEATH AND TUBERCULOSIS AS AFFECTED BY STANDARD OF LIVING. By Bailey B. Burritt. Published by the State Committee on Tuberculosis and Public Health, State Charities Aid Association, New York 28, N. Y. 1948. 16 p. 50c.

FROM NOPHN HEADQUARTERS

EARLY 1949 MEETINGS

The NOPHN Board of Directors met on January 28 in New York City. On January 27 there was a meeting of the boards of the six national nursing organizations with the Committee on Structure of National Nursing Organizations, and on January 29 a meeting of the Joint Boards of Directors—ANA, NLNE, and NOPHN, and of the boards of the six national nursing organizations.

The annual meeting of the NOPHN Council of Branches will take place on February 17 and 18, at the Stevens Hotel, Chicago, Illinois.

NEW STAFF APPOINTMENTS

Mrs. Helen Nelson joins NOPHN in February as assistant director in public relations. Mrs. Nelson has a bachelor's in journalism from the University of Missouri. From 1945 to 1947, under varying auspices, she was director of publicity for the Goodwill Industries fund campaign, wrote publicity for the Museum of Modern Art, and for hospital building campaigns. From 1942 to 1945 she was reporter on the St. Louis *Star-Times*.

Mrs. Jeannette C. Johnson, instructor in education, New York University, and supervisor of functional training, Institute for the Crippled and Disabled, New York City, has joined the staff of the Joint Orthopedic Nursing Advisory Service on a six months' appointment to carry forward work on visual aids until a permanent appointment is made in July. Mrs. Johnson is a graduate of the Augustana Hospital School of Nursing, Chicago, Illinois, and holds a public health nursing certificate from the University of Minnesota and physical therapy certificate from New York University.

SCHOLARSHIP COMMITTEE MEETS

A meeting of the Scholarship Committee of the Joint Council on Orthopedic Nursing (formerly the Joint Committee on Orthopedic Scholarships) was held on December 30, 1948 in New York City. This meeting marked the reorganization of this committee as a subcommittee of the Council. Committee members for the 1948-1950 biennial period are:

Jean Barrett, director, Department of Nursing, Syracuse University; Mary M. Dunlap, associate professor of nursing education, University of Chicago; Leeta A. Holdrege, director, Visiting Nurse Association of Omaha, Nebraska; Ann Magnussen, director, Disaster Nursing and Nurse Enrollment, American Red Cross; Jessie L. Stevenson, associate professor of nursing, Vanderbilt University; and from JONAS staff, Louise Suchomel, Lois Olmsted, and Lucy Blair. *Ex-officio* members are Dr. Jessie Wright, Agnes Gelinas, Ruth Hubbard, Anna Fillmore, and Adelaide Mayo.

NEW MEMBER AGENCIES

The Eligibility Committee met on January 14. NOPHN is happy to announce that the following agencies were granted membership:

Biddeford Public Health Nursing Association, Inc., Biddeford, Maine
Sudbury Public Health Nursing Association, Sudbury, Massachusetts
Wausau Visiting Nurse Association, Wausau, Wisconsin
North Shore Visiting Nurse Association, Winnetka, Illinois
Public Health Nursing Association of Mansfield, Inc., Storrs, Connecticut
Visiting Nurse Association, Gary, Indiana
North Providence Visiting Nurse and Tuberculosis Association, North Providence, Rhode Island
Visiting Nurse Association of Orange County, Inc., Santa Ana, California
Avon Public Health Nursing Association, Unionville, Connecticut
Needham Visiting Nurse Association, Needham, Massachusetts
Woburn Visiting Nurse Association, Woburn, Massachusetts
Visiting Nurse Organization of Pottstown, Pennsylvania
Public Health Nursing Association, Litchfield, Connecticut

Members of the Committee present were: Mary Harrigan, chairman, Edna Moorhouse,

New NOPHN staff members—Mrs. Helen Nelson and Mrs. Jeannette C. Johnson.

Mary C. Mulvany, Mrs. Howard J. Runyon, Ann L. Schmich, Mrs. Helen Watkins, Harriet F. Young, Mrs. Raymond E. Lease, and Dorothy Rusby and Ruth Fisher of the NOPHN staff.

100 PERCENT FOR 1949

It is a pleasure to publish this first list of public health nursing agencies with 100% individual membership in the NOPHN for 1949 and to express our appreciation for this fine show of support. We are aware that this list is probably far from complete but have included only those agencies from whom we have received notification that every member of the staff has become a member of her National Organization. Another list will be published soon. Should your agency be included? Please let us know!

DISTRICT OF COLUMBIA
Washington—Kiwanis Club, Crippled Children's Clinic

ILLINOIS
Quincy—Adams County Tuberculosis Association

INDIANA
Terre Haute—Vigo County Nursing Service

MAINE
Wilton—South Franklin County Tuberculosis and Health Association

MASSACHUSETTS
Duxbury—Nurse Association
Lowell—Visiting Nurse Association

MISSOURI
Clayton—St. Louis County Metropolitan Life Insurance Nursing Service

NEW YORK
Batavia—Metropolitan Life Insurance Nursing Service

OHIO
Cleveland—Visiting Nurse Association

PENNSYLVANIA
Reading—Visiting Nurse Association

TENNESSEE
Nashville—Metropolitan Life Insurance Nursing Service

VIRGINIA
Portsmouth—Metropolitan Life Insurance Nursing Service

WISCONSIN
Neenah—Health Department

HAWAII
Honolulu—Board of Health

MRS. BOLTON RECEIVES MEDAL

Frances Payne Bolton, Representative in Congress from Ohio, and one of the great benefactors of nursing in this country, was presented with the William Freeman Snow Award for Distinguished Service to Humanity on February 2 in Washington, D. C. The occasion was the annual program meeting of the American Social Hygiene Association.

Accepting the award Mrs. Bolton said:

> We have a goal here in America—a vision, which, though often dimmed perhaps, still lives in our minds and hearts. We see before us, ever beckoning, this land of our dreams, our desires, our hopes and our determined efforts; a land where children will be born with fine strong bodies, keen minds and understanding hearts into homes where love and kindness dwell; a land in which each may have the education

and training best suited to his capacity and work adequate for his need—a land where there may be in addition a bit of laughter, and time to enjoy the beauty of God's world.

Mrs. Bolton then spoke of the new global conception of disease prevention, in particular, against the venereal diseases. She mentioned the spectacular scientific gains in the fight against VD, and the need for the teamwork of education, recreation, social protection, and law enforcement in stamping it out. She stressed the part of public health nursing in the team, "All groups must share the responsibility for the eradication of the scourge of VD and all professional groups work shoulder to shoulder in full partnership. To me the Public Health Nurse is so important a factor in the whole picture, that as I have been able I have joined with many others of like minds to see that she is equipped with knowledge and then freed to make the intimate often very difficult educational contribution in the homes of our people."

Mrs. Bolton concluded, "With the memories of our yesterdays fresh in our thoughts, the grim facts of today challenging us at every turn and Tomorrow beckoning, we can look forward confidently to a New Day for health and welfare."

NOVEMBER REPRINTS

Two reprints from the November magazine are now available—"Communicable Disease Nursing—1948" by Margaret Shetland, R.N. and "Facilities for Health in Public School Buildings" by W. W. Patty and K. W. Bookwalter. These are free to members upon request, and 15 cents and 10 cents respectively to nonmembers. On orders of less than $1 money must accompany the order.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Council of Branches Meeting	
Anna Fillmore	Chicago, Ill.—Feb. 17, 18
Mary T. Collins	
M. Olwen Davies	
Ruth Fisher	
Jean South	
Marie Swanson	
Other Field Trips	
Anna Fillmore	Washington, D. C.—Feb. 3, 4, 5
Lucy E. Blair	Denver and Boulder, Colo—February
Mary T. Collins	Chicago, Ill.—Feb. 16
Dorothy Rusby	Worcester, Mass.—Feb. 23-25
Elizabeth Stobo	Nashville, Tenn.—Feb. 9-11
	Albany, N. Y.—Feb. 16-18
	Rochester, N. Y.—Feb. 23-25
Louise M. Suchomel	Montclair, N. J.—Feb. 1

January field trips included a visit to Somerset County, N. J., by Hedwig Cohen.

ABOUT PEOPLE WE KNOW

Word has just been received of the retirement of *Nellie M. Jones* as director of the Public Health Nursing Division of the Vermont Department of Public Health. She is succeeded by *Esther L. Martinson*. . . . New arrivals in Alaska for service under the Alaska Department of Health are public health nurses *Lynette Mann, Mrs. Ruth Fulton,* and *Mrs. Beth L. Brooks.*

Vera Knickerbocker has recently been appointed director of public health nursing with the Merced County Health Department of California. . . . *Elizabeth Goforth* has returned to her duties as director of public health nursing education for the City-County Board of Health of Louisville, Kentucky while *Margaret Dill* who has served as acting director has rejoined the staff of the ARC in Washington, D. C. . . . *Mary Frances Benedict* has received an appointment as counselor and consultant of the Counseling and Placement Service of the New York State Nurses' Association. . . . *Harriette M. Malone* has joined the staff of the Social Hygiene Committee of the New York Tuberculosis and Health Association. . . . *Mrs. Bessie Frey* assumed her new duties as nursing supervisor of the Visiting Nurse Association, Spartanburg, South Carolina, on November 1, 1948. . . . *Lucy C. Perry* has been appointed to the faculty of the Division of Nursing Education, School of Education, Indiana University.

NEWS AND VIEWS
FROM FAR AND NEAR

YALE NURSES CELEBRATE

The Yale University School of Nursing will celebrate its 25th Anniversary on February 5. Mrs. August Belmont and Dr. Alan Gregg will be the guest speakers. Also scheduled to speak are James Rowland Angell, president emeritus of the university, and Dr. C.-E. A. Winslow.

The Yale School of Nursing has never deviated from the objective outlined by Annie W. Goodrich, its first dean, who declared, "The nurse must be scientifically informed, technically skilled and socially experienced." In its 25 years the Nursing School has charted new paths in its philosophy of nursing education, emphasizing the development of the normal human being, prevention as well as the care of sickness, and the responsibility of the nurse in programs for the health of the peoples of all nations.

The Yale School was authorized in 1923 as the result of a gift from the Rockefeller Foundation and its first students—11 in number—were admitted February 7, 1924. Until 1926, students completing the 28-month course received certificates of nursing. From 1926 to 1934 two years of college studies were required for admission and the Bachelor of Nursing degree was established. In 1933 the Yale Corporation voted to place the School on a graduate basis by requiring the completion of a 4-year college course for admission and authorizing the Master of Nursing degree, first conferred in 1937. The School was then under the leadership of its second dean, Effie J. Taylor.

To date the Yale School of Nursing has graduated 934 students.

Elizabeth S. Bixler, dean since 1944, says: "I think for the advance of the profession, all nurses of the future should have college degrees. We think of nursing as a real profession, and because of the demands made upon those who are in it, nurses should be just as well prepared as possible to cope with the responsibilities that the professional nurse must face."

MLI CELEBRATES ANNIVERSARY

The Metropolitan Life Insurance Company is celebrating the fortieth anniversary of its Health and Welfare Division and visiting nurse program.

This pioneer venture of an insurance company into the fields of health and welfare was initiated in 1909 through the vision of three leaders: Mr. Haley Fisk, then president of the Metropolitan; Dr. Lee K. Frankel, first director of the Division; and Lillian Wald, director of the Henry Street Settlement, who suggested the nursing service to Dr. Frankel.

NON-NURSE TEACHERS FOR HOME NURSING

After three successful experimental studies, the American Red Cross has authorized the training of carefully selected non-nurses as instructors of the basic home nursing course, Unit I, "Care of the Sick," in communities where there are insufficient nurse-instructors. In broadening policy to extend the Home Nursing program into communities having fewer nurses and where instruction is needed, ARC is also "up-grading professional nurse-instructors to the status of teacher-trainers or instructors of classes that present special problems. Unit II, "Mother and Baby Care and Family Health" will continue to be taught only by professional nurses.

The Red Cross is authorizing its chapters

to begin to train, authorize, and supervise selected non-nurse instructors to teach Unit I. In doing so the stipulation is made that: Plans should be developed cooperatively with departments of health and education. Plans should be developed only in such centers where there is evidence of lack of nurse instructors sufficient to meet the need or in educational institutions which prefer to use their own teaching staff. Non-nurse instructors should be trained by professional nurses who are also authorized Red Cross training supervisors. Non-nurses who are to be trained as instructors are to be given not only careful training but also continued supervision, especially during their first year of teaching. Non-nurse instructors, so far as possible, should be persons with teacher or leadership training or experience.

PROTECTING AGAINST TB

Safer Ways in Nursing to Protect Against Tuberculosis is a new publication prepared by the Joint Tuberculosis Nursing Advisory Service. It is planned primarily for those in hospitals and public health agencies responsible for selecting and implementing measures to prevent the spread of tubercle bacilli. It should also serve as a resource for teachers of nursing who are the key people developing understanding of principles underlying safer practices and the attitudes which support them.

The booklet is intended as a guide for the development of effective aseptic technics, an essential in preventing the spread of tuberculosis. It is not the "last word." Further medical research will provide the final answers to moot questions.

Single and quantity copies can be secured from local tuberculosis associations.

CARE SEEDS FOR EUROPE

Thirty-one selected varieties of vegetable seeds, enough to plant a garden up to 50 by 150 feet, are contained in a CARE package designed for family use. Another, weighing 20 pounds, holds enough hybrid field corn to plant 2½ acres and provide valuable feed for fattening meat animals or maintaining a high level of production in dairy cattle.

The new CARE packages are $4 each and orders may be placed with CARE at 50 Broad Street, New York 4, for guaranteed delivery in 11 European countries. Orders should be sent at the earliest possible date to insure delivery in time for the planting seasons.

FACTS ABOUT NURSING—1948

The first authoritative survey since the war among U. S. nurses, recently conducted by the American Nurses' Association, reveals that there are today 435,000 registered professional nurses in this country, of which only 280,500 or 64.5 percent are active. Of these, the largest concentration are practicing in the Middle Atlantic states.

These data and many other vital statistics obtained by the survey, together with the latest information on important developments in nursing, are contained in "Facts About Nursing, 1948," recently published by the ANA, cooperating with the NLNE, NOPHN, ACSN, NACGN, and AAIN.

The new data-packed "Facts" contains more accurate and up-to-date information about the nursing profession than has ever been available heretofore. Contents have been reorganized under new chapter and section headings for more convenient reference. In addition, a brief text pointing out the highlights in the various tables has been added at the beginning of each section.

An important feature is the estimate of the number of professional nurses in the United States for 1948, broken down by geographic area and field of nursing. Others are the chapter on the six national nursing organizations and the Red Cross, and a list of sources of other studies concerning nursing which have been published recently or are in progress.

"Facts About Nursing, 1948" reveals that the number of professional nurses in hospitals and schools of nursing increased 13.4 percent from 1946 to 1947. In addition, the number of public health nurses and the number of professional nurses employed by government

agencies rose in 1948, compared with the previous year.

On the other hand, enrollment of student nurses on January 1, 1948, totaled 91,643, a drop of about 14 percent from the 106,900 students enrolled on January 1, 1947. The 1948 enrollment is about the same as the total on January 1, 1942.

The new edition of "Facts" contains a wealth of information on distribution, counseling and placement, and employment conditions of nurses which has been collected from the American Hospital Association, AMA, USPHS, ARC, and various governmental agencies. Additional material was provided by the statistical departments of the national nursing organizations which cooperated in compiling this book. Copies sell for 35 cents each.

● The National Foundation for Infantile Paralysis has announced that short courses will be given in the diagnosis and treatment of poliomyelitis patients for physicians, nurses, physical therapists, and occupational therapists. For nurses the courses are scheduled in three cities, as follows:

City Hospital, Cleveland, Ohio:

July 11-16, August 1-6, August 22-27, Sept. 12-17

Write John A. Toomey, M.D., Dept. of Contagious Diseases

Children's Hospital, Boston, Mass;

One and two months starting simultaneously June 27 and October 3

Write Muriel B. Vesey, Director, School of Nursing University of Colorado Medical Center, Denver, Colo.:

Jan. 24-Feb. 12, April 11-30, Oct. 3-22

Write Henrietta A. Loughran, Director of School of Nursing

In addition to the above, courses for physicians, nurses, and physical therapists are also offered throughout the year at the D. T. Watson School of Physical Therapy, Leetsdale, Pennsylvania. For information regarding dates, and to arrange for enrollment, write to Dr. Jessie Wright, Director.

Physicians and nurses who need financial assistance to attend these polio courses should contact their local chapters of the National Foundation.

For further information about the courses, write the school representatives named above.

● A workshop on Coordination of Education and Nursing in Centralized Programs (with particular application to institutions under diocesan and religious community control) will be conducted June 10 to 21, 1949, Catholic University of America, School of Nursing Education.

For additional information write to Sister M. Olivia, Dean, School of Nursing Education, Catholic University of America.

● The National Society for the Prevention of Blindness will hold a 3-day national conference, March 16, 17, and 18, 1949, at the Hotel New Yorker, New York City. The theme of the meeting will be "The Battle Against Blindness—the Next 40 years." Subjects discussed will be Eye Problems in Middle Life; Eyes of Children and Young Adults; Vision in Industry; Medical Advances in Sight Conservation; Glaucoma—A Community Problem.

● The Association for Physical and Mental Rehabilitation will hold its third annual convention at the Hotel New Yorker in New York City, May 18-21, 1949. More than 500 representatives from the nation's Veterans Administration, Army, Navy, and civilian rehabilitation agencies will be present.

● The International Council for Exceptional Children is holding its twenty-fifth annual convention at the Fairmont Hotel in San Francisco, California, from February 28 to March 3, 1949. The ICEC is composed of educators and social workers interested in the problems of the handicapped child.

● A national conference of social legislation, sponsored by the National Social Welfare Assembly, Inc., was held in New York, January 31 to February 1, 1949. Its purpose was to provide a forum and discussion medium regarding the "Why?" and "What?" of proposed Federal social legislation in the broad areas of social security, health, education, housing, and children and youth.

● Four 1949 Volunteer Bureau Workshops in Chicago, Galveston, Santa Barbara, and in New England, will be held the two days preceding the regional conferences of Community Chests and Councils of America. The workshop program is designed for the leadership, volunteer and professional, concerned with community organization for the participation of citizen volunteers. This would include advisory boards, committee members and professional staff of volunteer bureaus; members of committees on volunteers; community welfare council leaders in places interested in providing some coordinated channeling service for the work of volunteers; and for members of organizations concerned with setting up agencies to secure participation of volunteers. For further information write to Community Chests and Councils of America, 155 E. 44th Street, New York 17, N. Y.

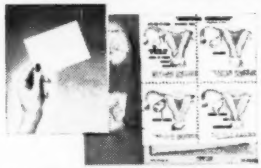
By Walt Disney Productions, this film combines grace and warmth with scientific perfection. Widely acclaimed by many thousands of teachers, parents and teen-age girls who have seen it. A 16 mm. full-color sound print is available, free, on a short-term basis.

The Story of Menstruation

FREE EDUCATIONAL FILM READY TO LEND TO SCHOOLS

You'll want your students to see this new motion picture because it teaches them so much. Tells young girls in a calm, straight-forward tone much they should know about a natural body function. Removes silly superstitions, conquers needless embarrassment. Points the way to mental and physical fitness.

MORE FREE TEACHING AIDS



"Very Personally Yours"
a booklet based on the film. Contains supplementary material for review and reference.

Menstrual Physiology
large, full-color chart for use by instructor during lectures. Shows the menstrual process in easy-to-follow diagrams.

SIMPLY MAIL THIS COUPON

Educational Department
International Cellucotton Products Co.
919 North Michigan Ave., Chicago 11, Illinois PHN-29

Please send me free, with the compliments of Kotex*, the following material:

☐ Full details on the Movie, "The Story of Menstruation."
☐ Copies of the new booklet, "Very Personally Yours."
☐ One full-color, jumbo-size Menstrual Physiology chart.

Name _____

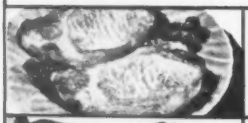
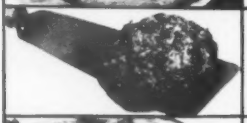
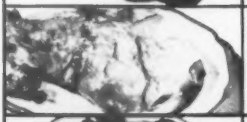
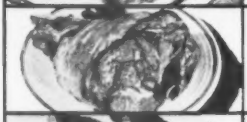
Title or Position _____

Address _____

City _____ *State* _____

*T. M. Reg. U. S. Pat. Off.

The Abundant Nutrient Values of MEAT

KIND OF MEAT	COMPLETE PROTEIN	B VITAMINS			FOOD IRON
		THIAMINE (B_1)	RIBOFLAVIN (B_2)	NIACIN	
 PORK	EXCELLENT	EXCELLENT	FAIR	EXCELLENT	EXCELLENT
 BEEF	EXCELLENT	FAIR	EXCELLENT	EXCELLENT	EXCELLENT
 LAMB	EXCELLENT	FAIR	GOOD	EXCELLENT	EXCELLENT
 VEAL	EXCELLENT	GOOD	GOOD	EXCELLENT	EXCELLENT
 VARIETY MEATS (LIVER, HEART, KIDNEY)	EXCELLENT	EXCELLENT	EXCELLENT	EXCELLENT	EXCELLENT
 SAUSAGE (FRANKFURTERS, BOLOGNA)	EXCELLENT	GOOD	GOOD	GOOD	EXCELLENT

ALL VALUES ARE BASED ON COOKED MEATS . . . MEAT ALSO SUPPLIES SIGNIFICANT AMOUNTS OF COPPER AND PHOSPHORUS

While its high content of biologically complete protein ranks meat among man's best protein sources, its contribution of many more indispensable nutrients further enhances its over-all desirability in the daily dietary.

As is readily seen in the chart above, every kind of meat is an excellent source of high quality protein and of iron. Meat further supplies significant amounts of the three B complex vitamins, thiamine, riboflavin and niacin. Certain cuts and kinds of meat are, as a matter of fact, among our richest food sources of thiamine and niacin. All meat, regardless of grade or cut, makes these contributions.

Due to the excellent digestibility of meat—from 96 to 98 per cent—the metabolic availability of its protein and other nutrients is virtually assured, making it particularly valuable in many disease conditions in which these nutrients are especially needed.

AMERICAN MEAT INSTITUTE

Main Office, Chicago . . . Members Throughout the United States

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

NO OTHER RUB GIVES FASTER RELIEF IN CHEST COLDS!

To Relieve Coughs—Aching Muscles

Musterole *instantly* starts right in to relieve coughs and tight aching soreness in chest muscles, because Musterole helps break up congestion in upper bronchial tubes, nose and throat. Musterole offers ALL the advantages of a warming, stimulating mustard plaster—yet it is so much easier to apply. Just rub it on!

CHILD'S MILD

MUSTEROLE

SCHOOL TIME *IS* DERBAC TIME

ONE TREATMENT

WILL THOROUGHLY RID HEAD OF LICE & NITS

DERBAC SERVICE—Dept. 2
334 East 27th Street, New York 16

Please send, without charge:
Information about Derbac Treatment.....
Educational Leaflets and Posters.....
Name .....
School or Institution.....
Address .....

Ideal For Premature, Normal Babies

Babies Finish Evenflo Bottles Better!

Babies sometimes go to sleep before emptying their bottles because their limited strength is exhausted trying to get food thru a hard, stiff or collapsed nipple.

Not so with Evenflo. The Evenflo Nipple is soft and pliable *throughout* so that baby nurses by compression as well as suction, similar to breast feeding. The twin air valves keep air pressure in bottle constant, allowing formula to be withdrawn easily when nursed. Because they nurse Evenflo in comfort, babies get more benefit from their food and make better gains in weight.

Evenflo's patented air valves relieve vacuum, prevent nipple collapse.

It's this smooth nursing action of Evenflo's patented twin-valve nipple that has made it—

"America's Most Popular Nurser"

Evenflo*

"IT BREATHES AS IT FEEDS"

Complete 4 or 8-oz. Evenflo Nursers 25c at baby shops, drug and dept. stores. Separate parts 10c each.

* Patented

Approved by Doctors and Nurses

DEAD-DEAD-DEAD . . .

in 15 minutes or less!

EASIER-TO-APPLY

A-200

PYRINATE LIQUID

Kills head, body, crab lice and their eggs . . . on contact!

A-200 PYRINATE LIQUID has won general acceptance by the profession wherever it has been introduced. No other product of its kind has so many advantages.

The active ingredients are Pyrethrum extract activated with Sesamin, Dinitroanisole and Oleoresin of Parsley fruit, in a detergent water soluble base. The pyrethrins are well-known insecticides and Anisole is a well-known ovicide, almost instantly lethal to lice and their eggs, but harmless to man. The efficacy of A-200 was proved in 8,000 clinical cases in the District of Columbia jail.

Advantages of A-200 Pyrinate Liquid

A-200 is easy to use: no greasy salve to stain clothing, quickly applied, easily removed, non-poisonous, non-irritating, no tell-tale odor . . . one application usually sufficient.

A PRODUCT OF McKESSON & ROBBINS, INC., BRIDGEPORT, CONN.

POSITIONS AVAILABLE

WANTED—Qualified public health nurse for suburban Westchester County, 45 minutes from New York City. Service integrated with Nursing Division of Westchester County Health Department. Bedside and teaching program. Apply: P.O. Box 280, Mamaroneck, New York.

WANTED—Supervisors and public health nurses, Baltimore County Health Department. Population 248,000; suburban, industrialized and rural areas; county seat 8 miles from Baltimore. Generalized service including modern school health program, rapidly expanding up to 50 field nurses. One month's vacation; 5 day, 35½ hour week; sick leave; retirement plan. For use of personal car, allowance of 7 cents per mile. Supervisors: degree and experience required; salary $3200 to $3700; with additional preparation in child hygiene, venereal disease, mental hygiene or orthopedics, $3500 to $4000. Public health nurses, beginning salary $2300 (for trainee) to $2700, depending on experience and education; increases to $3300. Write: Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

WANTED—Supervising public health nurse for modern generalized nursing program. Minimum requirements, public health certificate or one year of graduate study in public health nursing. Salary range $278 to $318; 40 hour week; retirement plan; sick leave. Write: Charles A. Neafie, M.D., Director, Department of Public Health, Pontiac 15, Michigan.

OPPORTUNITY for several additional public health nurses in expanding generalized program. Completion of approved course in public health nursing required. Rural and urban experience offered. Some cars are available. Salary $3000 to $3696. Write: Director of Public Health Nursing, Alameda County Health Department, San Leandro, California.

WANTED—Maternal and Child Health State Nursing Consultant. Must have a degree; training and experience in either or both fields; supervisory experience in generalized rural public health nursing. Apply: Nursing Section, Colorado State Department of Public Health, 515 Majestic Building, Denver 2, Colorado.

WANTED—Supervising public health nurse for small staff of privately endowed organization on west coast. Five day week, one month vacation, car allowance, sick leave. Must not be over 35 years. Teaching experience necessary, work interesting and not confining. Chance for advancement. Apply: Box DC, NOPHN, 1790 Broadway, New York 19, N. Y.

WANTED—Well qualified public health nurse for Curry County, Oregon. Salary $300 per month plus travel allowance. Car essential. Write: Dr. Harold M. Erickson, M.D., State Health Officer, 1022 S.W. 11th Avenue, Portland 5, Oregon.

WANTED—Tuberculosis Nursing Consultant. Minimum three years' experience in supervisory or consultant position with public health agency. Additional preparation and experience in tuberculosis control. B.S. Civil Service status. Permanent. Apply: Harold M. Erickson, M.D., State Health Officer, 1022 S.W. 11th Avenue, Portland 5, Oregon.

WANTED—Experienced, well-qualified public health nurse to work in Marion County Health Department with student public health nursing training program. Salary open; ample travel allowance; permanent. Write: Dr. Harold M. Erickson, M.D., State Health Officer, 1022 S.W. 11th Avenue, Portland 5, Oregon.

WANTED—Public health nurses to fill vacancies in Health Department. Generalized service including maternal and child care, school health and communicable disease control. Immediate appointment on provisional basis. Starting salary $2400; 37 hour week; liberal vacation allowance; in-service training. Write: Bureau of Nursing, City Health Department, 125 Worth Street, New York 13, N. Y.

EXCEPTIONAL OPPORTUNITY for employment in new building. Registered nurses to staff new medical and surgical floors; 44 hour week; salary to start $200 to experienced graduates, laundry free; liberal paid vacation, holidays and sick leave. Housing available in new nurses home recently opened. Meals may be purchased in cafeteria at cost. Write: Director of Nurses, Mount Sinai Hospital, Chicago 8, Illinois.

WANTED—Supervisor for staff of 15 nurses; private organization; bedside care and maternity service; salary based on experience, 40 hour week; vacation with pay; sick leave; retirement plan. Requirements: thorough field experience; 1 year of postgraduate study; some knowledge of supervision. Opportunity for advancement. Write: Visiting Nurse Association, 316 Elizabeth Street, Utica 3, New York

WANTED—Education supervisor. Challenging opportunity in a combined agency financed by official and non-official funds. Generalized program; graduate affiliation with two university programs. Staff consists of 13 public health nurses; 1 clinic nurse, 1 general supervisor, 1 educational supervisor, 2 secretaries, 1 clerk. One hour from New York City. Salary open. Apply: Box DC, NOPHN, 1790 Broadway, New York 19, N. Y.

Report Your New Address

Please report change of address direct to PUBLIC HEALTH NURSING, allowing 6 weeks before change is to take effect. (Be sure to send your old address together with the new address.) Copies that *have been mailed* to an old address will not be forwarded by the Post Office unless extra postage is sent to the Post Office by the subscriber. Avoid such expense, and make sure of getting your copies promptly, by notifying PHN in advance.

Spring's in the Air!

NOW'S THE TIME TO ORDER YOUR OFFICIAL NOPHN SUIT AND UNIFORM

GABARDINE SUIT

Custom-tailored to your individual measures of finest navy blue 100% wool gabardine.....**$52.50**

Extra skirt.....**$17.50.** Overseas cap.....**$4.50**

POPLIN DRESS

Of beautiful quality — sanforized, washable and colorfast. It's extra full and extra long with 10" zipper opening. 2 pleats in front and snap-in shoulder pads.

Sizes 10 (full) to 46 (full). **$8.45**

Detachable white collars....**60c** each.

Extra white bows....**35c** each

***Also NOPHN official Seersucker Dress (short sleeves)* $8.45**

TO ORDER suit or dress send measurements, height, weight and dress size. Enclose $20 deposit for suit and $2 deposit for dress. Balance C.O.D.

HOPKINS Tailoring Co.

107 W. FAYETTE ST. BALTIMORE 1, MD.

Place of Honor... for TWO!

Two styles . . . so easy to love that you'll award them a place of honor in your wardrobe.

So carefully designed, they'll work wonders for your figure . . . so long-wearing, they'll make your pocketbook happy too!

STYLE 9100

- Navy Blue dress made of Sanforized, 2-ply combed yarn Poplin
- Short or long sleeves
- Pleated, action back
- 7-gore, fly-front skirt
- Worn with or without white detachable over-collar

SIZES 10-20, 40-46 ..... $8.50

Separate Collar ..... .50

STYLE 666

- Official NOPHN dress
- Navy Blue Sanforized Poplin
- Regular or long-waisted
- Attached collar of self-material
- Can also be worn with white over-collar

SIZES 10-20, 40-48 ... $8.50

Separate Collar ..... .60

ORDER NOW—ASK FOR FREE CATALOGUE

OR VISIT OUR SHOPS

New York • 387 Fourth Avenue
Detroit • 2539 Woodward Avenue
Pittsburgh • 627 Smithfield Street
Chicago • 17 N. State Street

MAIL ORDERS TO →

When ordering by mail, please give regular dress size, bust, waist, hip measurements, weight and height. ASK FOR FREE CATALOG.

BRUCKS

Dept. PH-2
387 Fourth Avenue
New York 16, N. Y.